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ABSTRACT

The proceedings cover a conference of representatives of all the community colleges in the southern part of Illinois and one in Kentucky with representatives from the School of Technical Careers at Southern Illinois University. The conference objectives were to discuss common problems and issues related to closer coordination of effort among the participating institutions. A cooperative nursing program among the schools has been effective, and representatives of the institutions believed further cooperative ventures were desirable. In providing a focus for the workshop conference, six papers were given following a welcome speech by W. E. Malone of SIU: a paper on expanding opportunities for the occupational education student by K. G. Skaggs; on career mobility by J. H. Smith; curriculum flexibility by Ralph Kuhli; accrediting and credentialing limitations on flexibility by Don Frey; operational limitations on flexibility by Lori Reibling; and suggestions for living with the limitations by S. V. Martorana. A page of commentary; a list of attendees, speakers, and resource persons; an allied health fact sheet; and a map of the geographical area showing the location of participating institutions are included in the proceedings. (AG)

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MAY 10-11, 1973

PROCEEDINGS OF THE CONFERENCE

NEW DIRECTIONS IN POST-SECONDARY EDUCATION

EXPANDING OPPORTUNITIES for the OCCUPATIONAL EDUCATION STUDENT

edited and with an introduction by

TERENCE BROWN, CONFERENCE COORDINATOR

sponsored by

THE SCHOOL OF TECHNICAL CAREERS OF

Southern Illinois University at Carbondale

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INTRODUCTION

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The history of significant cooperation among post-secondary educational institutions in Illinois is a short and rather unremarkable one. However, within recent years, educational leaders in most of the post-secondary educational institutions in southern Illinois have become increasingly aware of the necessity for inter-institutional cooperation. This awareness is predicated from several realities: the fiscal crunch, the diversity of needs of contemporary students, and the inability of any one institution to be all things to all people. This awareness coupled with the geographic proximity of many of the post-secondary educational institutions in southern Illinois created in the minds of many of these educational leaders the solution to a known but largely inarticulated problem. However, this solution, that we join forces and resources in mutual, enlightened self-interest for the common good of everyone concerned, needed an example. This example was found when the growing need for a locally available associate degree in nursing program became more and more pressing.

Each of four community colleges in the immediate area of Southern Illinois University at Carbondale currently operates a licensed practical nursing program. Further, the School of Technical Careers of Southern Illinois University at Carbondale has had extensive experience in the operation of a licensed practical nursing program, the program now at Logan College having once been operated by the School of Technical Careers Manpower Skill Center. Therefore, the common desire

for registered nurse production in downstate Illinois coupled with the common realization of the fiscal impossibility of achieving this production singly brought together leaders of John A. Logan College, Carterville, Illinois; Rend Lake College, Ina, Illinois; Southeastern Illinois College, Harrisburg, Illinois; Shawnee College, Ullin, Illinois; and the School of Technical Careers, Southern Illinois University at Carbondale, Carbondale, Illinois, to seek a common solution to this mutual problem. The first efforts in this direction were initiated in the spring of 1972. First, the fences of the old educational territorialism had to come down, and bridges had to be built to replace them. This work was accomplished in an astonishingly short time. Each school seemed to be waiting for an overture from the other. It was as if the whole idea of cooperation was a great idea whose time had come. Representatives of the five involved institutions came together with remarkably little suspicion and a great deal of trust, great expectations, and a genuine desire to remedy mutually the educational needs of southern Illinois. Of course, Southern Illinois University at Carbondale, one of the nation's giants in education, had the longest history of institutional territorialism to repudiate, and the repudiation of such a history of educational empire building is not accomplished overnight. Indeed, Southern Illinois University at Carbondale still finds itself guarding against and, perhaps on occasion, over-reacting to any seeming attempt to take advantage of its peers in this mutual undertaking.

Throughout the spring and summer of 1972, informal liaisons among the involved institutions became frequent, casual, and increasingly helpful. The atmosphere of trust thus created made it possible, in the fall of 1973, for

officials of the five institutions to meet in Marion, Illinois, a more or less central location, to discuss the possibilities of a systematic effort to secure recognition and funding for what was by this time acknowledged to be a jointly operated single nursing program. At this first of a series of meetings, it was decided that the group would informally join together as the Southern Illinois Nursing Consortium to seek official recognition from the National League for Nursing as an open curriculum pilot project site. It was an extremely fortuitous circumstance that the NLN had secured from the Exxon Foundation a grant to deal with open curriculum planning and implementation. Since the kind of nursing program envisioned by leaders of the five schools was in fact an open curriculum program, it seemed a perfect opportunity to coalesce into a functioning unit by having individual members band together and agree upon the informal document that became a proposal to the NLN. This mutually conceived strategy bore the mutually expected result. Not only did the group agree for the first time to put something in writing and then agree on what it had put in writing, but the document that resulted had a significant purpose.

This proposal to the NLN was mailed in late 1972. A natural progression of ideas then led the group to determine to seek federal funding for the proposed nursing program. Of course, the decision to seek federal funding for the program introduced various kinds of problems, not necessarily those faced in the amicable world of visionary, blue sky projections. For example, the obvious problems of a group writing a single proposal for a federal agency are several: who contributes the staff time to develop the proposal, who provides policy guidelines for use in the development of the proposal, who

will be the fiscal agent if the proposal is accepted, and what kinds and amounts of grantee contributions must be guaranteed within the proposal? While there were discussions of these and other such points, accord was reached in remarkably little time. This proposal, which dealt in some detail with programmatic instances, was mailed in January, 1973. The NLN recently selected the nursing program as one of several national open curriculum pilot project sites. The National Advisory Council in Nurse Training will soon decide the fate of the group's proposal for federal funding.

Simultaneously with this program development activity, a new educational entity evolved in southern Illinois. This entity, the Southern Illinois Collegiate Common Market, had been talked about for some time by former executive director of the Illinois Board of Higher Education, James B. Holderman, by other officials throughout the state, and by individuals in various southern Illinois post-secondary institutions. Indeed, the IBHE even made a small grant to help create SICCM. Within a short period of time, each of the involved schools, John A. Logan College, Rend Lake College, Southeastern Illinois College, Shawnee College, and Southern Illinois University at Carbondale, also pledged certain funds to the creation of SICCM. By January, 1973, SICCM had been translated from idea to reality and shortly after the first of the year, Mr. Ron House had been named the first coordinator of the Southern Illinois Collegiate Common Market. Obviously, the nursing program that had already been nurtured by each of the five institutions became the first SICCM program.

The circulation of copies of the nursing proposals, news releases concerning the creation of SICCM, and the designation of the nursing consortium as a National League for Nursing Open Curriculum Pilot Project Site, all served to buy visibility and acceptance for the innovative Southern Illinois Collegiate Common Market and its fledging nursing program. The program, like SICCM, is simplicity itself. It is based on the knowledge that no institution can be all things to all people but that several institutions operating for a common cause can do more than any of the institutions may singly. Indeed, all the institutions operating together equal even more than the sum of the individual elements. The nursing program is exemplary of the SICCM approach to multi-institutional area educational problem solving. Here is a program needed by all the people of southern Illinois, and yet it is a program that cannot be easily supported by any of the institutions in southern Illinois. Obviously, SICCM and its nursing program are the logical conclusions of a rational process: problem and solution. The problem is the need for a nursing program in the face of the fact that no single institution in southern Illinois can successfully mount such a program, and the solution is that all the post-secondary institutions in southern Illinois join together and mount one mutual program that is, in effect, each participant's own program in which each participant can give its own degree.

One of the recipients of copies of the nursing proposals was Mr. Kenneth G. Skaggs, Specialist in Occupational Education with the American Association of Community and Junior Colleges in Washington, D.C. Mr. Skaggs, an old friend of occupational education and of nursing education, knew each of the

involved institutions, their problems, their aspirations, and their frustrations. He also applauded their solution in a significant way. Mr. Skaggs, when he read the proposals, was planning a cooperative project between the American Association of Community and Junior Colleges and the Commonwealth Fund of New York. This project had as its goal the development of exploratory activities to assess the status of universities as leadership and resource centers for community and junior colleges in the field of occupational education, to identify institutions that could aid in reaching the objectives of the project, to visit university and community/junior college personnel in order to assess the degree of their interest and willingness to work together to achieve leadership goals, and to identify with the university personnel those community-junior college leaders who would be invited to the initial meetings or discussions. Subsequent to those activities, the project would plan with the university a workshop-type meeting and prepare reports on the meetings and materials for publication and, finally, publish a report. In effect, some of the work of Mr. Skaggs' project had already been undertaken in southern Illinois. It was only natural, therefore, that he was warmly interested and genuinely excited about the work being done here. After reading the nursing proposals forwarded to him by the consortium of community colleges and Southern Illinois University at Carbondale, Mr. Skaggs immediately got in touch with the dean of the School of Technical Careers at Southern Illinois University, Dr. Arden L. Pratt, and came to southern Illinois to meet and plan with college and university personnel to be involved in his plans. In rapid-fire sequence following an initial meeting, the objectives of a workshop conference that would capitalize on gains already made and explore new areas of mutual

interest and cooperation were hammered out. It was determined during those initial meetings that not only would the four community colleges already involved in using Southern Illinois University at Carbondale's School of Technical Careers as a resource center be invited to the conference, but in addition all of the community colleges in downstate Illinois and even one in Kentucky, sixty miles south of Carbondale, would be involved in this workshop effort. The objectives of the workshop conference were stated as below:

1. The workshop will bring together personnel from a selected group of community colleges with the School of Technical Careers personnel to discuss common problems and issues relating to closer coordination of effort and more effective understanding of programs.

2. The workshop will focus upon the Southern Illinois Collegiate Common Market, the development of programs, the problems of the small and medium-sized community college in serving occupational education needs, the proposed emphasis upon allied health education programs, and problems of management and supervision. Specific areas for discussion are listed below:

    a. surveys of need leading to effective distribution in the geographic area
    b. effective curriculum development with flexibility to reflect technological change and advance
    c. the core curriculum

d. the credentialing system: accreditation of programs, licensure, certification, and registry, especially as these affect allied health programs

e. program evaluation and production-on-the-job evaluation

f. support of programs: student recruitment, university students, staffing, financing

g. upward mobility and transfer problems

h. liaison and communication with employer groups, professional agencies, and universities and four-year colleges

i. principles involved in effective clinical experiences for students involved in on-the-job experience

j. the problems of management and operation of programs in small or medium-sized community colleges and ways in which the School of Technical Careers may help, i.e., the one-plus-one program, sharing resources, etc.

Since health programs, particularly nursing, had already been selected as exemplary, it was determined that the workshop conference could successfully deal with the health program focus while underscoring the suggested concepts and the common market setting. All the conference goals seemed to reduce to several areas of significance: need, flexibility, program evaluation, open curriculum and the problem of management, operation of program in the small or medium-sized community college, and ways in which the School of Technical Careers could be a resource center. These objectives were then further reduced to three areas of significance: opportunity and

access for the individual students, an instructional process for dealing with individual students, and implementation and delivery of that process to the students. In short, the conference could serve American Association of Community and Junior Colleges and Commonwealth Fund of New York objectives and Southern Illinois Collegiate Common Market and nursing program areas of interest if the conference were designed to deal with mobility, flexibility, and cooperation. These general areas were then selected as areas with which to deal in the context of the program.

Considering all of the aspects to be covered by the conference, the title was determined to be "New Directions in Post-Secondary Education: Expanding Opportunities for the Occupational Education Student" because these were the ideas that the conference wanted to emphasize with particular emphasis on cooperation as a new means of expanding opportunities. It was determined that all felt needs could be served if, after a kick-off discussion on the entirety of the title subject, discussions were then offered on creating career mobility for students, maintaining curriculum flexibility to provide maximum career mobility, and suggesting how to make all of this work through cooperative resource sharing. As the program was developed, these categories were further refined and defined, and the final topics appear following the table of contents. An example of this refining and defining process is noted by the fact that it was found necessary to have three different persons talk about curriculum flexibility since this seemed most difficult to achieve within the context of present educational structures.

The conference seems to have been well received, and most of its immediate goals were accomplished. Of course, only time will tell of its ultimate results, but the future of cooperation among all the post-secondary educational institutions in southern Illinois has never looked brighter. A continuing dialogue has been established among educational leaders of proximate institutions. The Southern Illinois Collegiate Common Market is flourishing. Contractual agreements with non-SICCM schools are being initiated and implemented. Mutual need surveys and mutual program development are already a reality. However, before we can cooperatively rest on our cooperative laurels, it should be pointed out that much remains to be done. A conference such as this one should be a regular occasion, perhaps with rotating sponsorship responsibilities. Thus, regular dialogues would continually stir and revivify what may become the stale atmosphere of institutionalized, ritual cooperation on token programs, for even the best laid, most innovative plans for student and area benefits can become rigid, redundant, and useless without the constant vigilance that continuing dialogue creates.

It is singularly important to note that the primary goals that the conference intended to achieve are not retrospective, like this introduction, but prospective, and the future looks bright. It is the expressed hope of almost everyone attending that both the conference and this document can serve not only as a souvenir but also as a resource for the future, a cornerstone of a significant edifice of inter-institutional cooperation. It is noteworthy that most letters sent by various attendees in the wake of the conference all emphasize the idea that we all should continue in this sort

of effort; that the conference itself was beneficial and helpful; that it was worth time and money; indeed, that it should be the first of a series of perhaps yearly or even quarterly get-togethers at which many of the people involved in post-secondary education in the southern third and perhaps even the southern half of Illinois can come together to discuss common problems and propose common solutions. Therefore, it is important that this document seem less a conclusion to what has been and more an introduction to what will be.

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WELCOME

WILLIS E. MALONE
Assistant to the President
Southern Illinois University at Carbondale

In this program I see new directions; I see flexibility; I see opportunity; I see those words in the program. This is a very exciting time to be in higher education; but one of the greatest threats that may come to us from austerity, from the cutting back in budgets, is the fact that we will become too traditional, too orthodox. We will pull back from the campus and forget to do those things that really need to be done. This is the reason it seems to me that it is an inspiring time. Twenty-five years ago there were certain legal restrictions on our university. We could not offer the degree in medicine, the degree in law, the degree in agriculture, the degree in pharmacy, the degree in engineering. We can offer those now; the legal restrictions have been removed. Now the only restriction we have is our own creativity. Can we think outside the normal pattern of education and do things that very much need to be done? In education we are geared to time. We tend to think that everybody should register for the quarter or for the semester, that students should start the course at the same time and finish it at the same time. There is a real challenge because this is not the way it is going to be in the future. The basic question is are we smart enough to plan it and do it? I believe we have the ability to educate creatively, but we can no longer think specifically in terms of time. We have to think in terms of achievement and recognize that people learn in different patterns and in different time sequences. But Southern Illinois University at Carbondale is not geared that way, and I believe that community colleges are and are doing some things that need to be done.

Southern Illinois University is most proud to work in equal partnership with the community colleges in this area and throughout the state. We learn much from them; we want to be a partner to the community colleges and to the programs throughout the state. We are proud of their achievement, and we hope that Southern Illinois University at Carbondale can make some contribution in that particular regard.

Also, we must recognize, as we are beginning to recognize, the fact that we must get outside the classroom. At least we must recognize the value of the kind of experiences that people have outside the classroom and in our total educational programs. We must not think these experiences are cheap. We learn many things outside the class, and we do have many people who think that if classes meet three days a week or four days a week, then this is the way it should be. Perhaps it is right in some cases, but there are times when we ought to be outside the classroom, and we should not feel necessarily good because we have met the class everyday. Instead, communities have become tremendously important.

I taught in one-room girls' schools for a number of years; those schools belonged to the community. We knew a[illegible]e community then, and we worked a bit closer with the knowledge of the needs of the community and its people than we do now. Today we must recognize that people learn for a lifetime. Yet part of the job of a professor is to point to sources of information and somehow to develop on the part of people the desire to seek those sources of information and to utilize them. Today universities and colleges cannot simply gear their programs to the student who is eighteen to twenty-two years old. There is

another group of people who would like very much to gain knowledge of certain areas that are very important to these people. Somehow we must plan a new delivery system in order to get that knowledge to them.

We now have here in southern Illinois a consortium of community colleges with Southern Illinois University at Carbondale called SICCM, Southern Illinois Collegiate Common Market. This particular consortium is an attempt to plan programs that we can implement in unison but that we probably cannot even plan individually, and it is a good effort.

Consequently, I want to encourage educators to think in terms of new direction, to think in terms of opportunities, and to think in terms of flexibility. We must not think of what we should not do but of what we should do. We must never become too orthodox.

Under President Delyte Morris' leadership, Southern Illinois University at Carbondale for many many years grew in stature because it was unorthodox. Southern Illinois University at Carbondale became a center for crime and corrections, a rehabilitation institute, a vocational-technical institute, all those things that in many cases were not orthodox. Now the School of Technical Careers is attempting to chart a new mission, and the question really is this: Are we smart enough to dream ahead for another ten years or fifteen years to when this institution, working in equal partnership with the other educational forces in this part of Illinois, can do the kind of job that needs to be done?

NEW DIRECTIONS IN POST-SECONDARY EDUCATION: EXPANDING OPPORTUNITIES FOR THE OCCUPATIONAL EDUCATION STUDENT

KENNETH G. SKAGGS
Occupational Specialist
American Association of Community and Junior Colleges

The planning, development, and implementation of occupational education programs in the community and junior college, technical education centers, and post-secondary vocational centers over the past decade have indeed been the Cinderella story of higher education. At the beginning of 1966, about thirteen percent of the students enrolled in community and junior colleges initially entered occupational education programs of one sort or another. By 1972, just six years later, about forty percent of all students in community and junior colleges enrolled in occupational programs. This represents a total of about 1,200,000 students. This year, on the basis of a spot-type survey, about forty-three percent nationally of the enrollment in the community and junior colleges are in the occupational education programs or, more specifically, about 1,350,000 students. Some states of course reported even higher percentages.

Dr. William Dwyer, the director of regional colleges from Massachusetts reports that sixty percent of all the enrollment in the Massachusetts community colleges, or regional colleges as they are called there, are in occupational education. Other states report fifty percent, but the national average as we have judged it and assessed it is about forty-three percent of our students. However, from all indications the next decade is going to see this percentage increase, and more students will be coming into our occupational program. It may very well be that the growth in occupational education has been too rapid, and I think most of us have certain feelings about this. At least it is quite obvious that operational and support problems for these programs have become

acute. Recruitment problems over specialization of curriculum, difficulties in obtaining staff, saturation of the job market in some areas, ineffective evaluation and follow-up procedures, all are plaguing institutions that have entered the occupational education field.

On the other hand, we should not become so impressed with the difficulties in the occupational field that we lose sight of the many positive advances that have been made in serving the needs of a rapidly changing technology, the demands of society, and the objectives and goals of our students. Great progress has been made, and many of the negative criticisms that have come out of some reports and from liberal arts oriented educators are unfounded or factually distorted. Today allied health education programs and all educational institutions are in a crisis of change. Especially is this true of programs in the community and junior colleges of the nation. After a decade of unprecedented growth and stimulation, the colleges are facing changes, needs, and technologies with new demands from students as well as from employers.

As we examine the job market and the demands of the health and medical delivery system, we finally learn that there must be developed even more effective programs and that even greater use must be made of the nation's community and junior colleges to educate and prepare manpower for health and medically related occupations. The same is true of other occupational areas.

If a majority of Americans are to have the benefit of educational experience beyond high school, there must be avenues of opportunity distinct from what might be called conventional college preparation. These avenues have already been paved and opened in many community and junior colleges across

the country. Such avenues constitute a growing segment of the programming in two-year colleges. The programs are designed to prepare men and women for sophisticated, technical, and semi-professional jobs in all occupational and career fields.

The National Advisory Committee on the junior college has perhaps best expressed the need and the planning required for these programs. However, it must be clearly understood by those responsible for education at all levels that middle-level job education is a legitimate function of higher education and that the junior college is an appropriate instrument for this purpose. Until such an understanding is reached, it will be impossible to move forward rapidly and wisely enough in planning for the future.

Certainly in occupational education we are seeing signs today of this almost incredibly rapid growth, of the gathering storm that is coming to our campuses in terms of these programs. I am not negative about these programs, and I want to emphasize once again that while we can look at issues and problems and concerns, we must also not forget that we have made great advances. We have offered educational opportunity to many young Americans and to older Americans, too, who would not have these opportunities had we not existed and had we not planned and developed these programs. But we do have some problems ahead.

What are some of these problems? One is budget. Let us be very frank with ourselves. Occupational education programs are costly. They cost more than a general education or a liberal arts program. Some states have recognized this and are giving, in terms of their support of education, more money for

students enrolled in occupational education than they are giving for students enrolled in general education, liberal arts, or transfer courses. The cost of programs is high. Yet we must look at this and be realistic about it.

Also, in terms of budget, the time for easy money has passed at least for the next few years. We are not going to be able to find money as easily to support programs. Many of our occupational programs are going to have to be supported from our own budgets, and then come the great questions of where do we cut, what do we do, and what can we do to reduce the cost of programs. These are the essential questions.

I am not certain that we can come up with easy answers, but I believe that we must begin to look for ways by which we can develop and implement and offer programs at less cost than we are now doing simply because these costs are a matter of great concern in terms of budget planning.

Second in the gathering storm in occupational education on our campuses is manpower needs. What are the true manpower needs in terms of developing programs? If we plan, develop, and implement a program, if we recruit students, bring in a faculty, go to all the expense of the program, and if we put students through this program and then these students cannot get jobs because the jobs are not there, we can neither justify our taxpayers supporting this program nor can we justify our recruitment. These students must have jobs. Consequently, we must take a good, hard, long look at the job market and manpower needs.

Everywhere we turn today we are beginning to hear people talk about the saturation of manpower needs or the saturation of the market in terms of people getting jobs. We have been quite fortunate in the last few years, for we have seen our students go out and get jobs. I made a commencement speech at a community junior college not too long ago. We had 740 young people in that graduating class. It was a rather large community college, and the president was very proud that ninety-six percent of all his students who were not transferring to a university for further education and had come out of the occupational education programs already had jobs. He was quite sure that the other four percent would get jobs if they wanted them. This is a remarkable kind of record, but how long can we sustain it?

Today we do not have very good manpower survey reports. We do not have an accurate assessment of what the real problem is. There are places in this country where we have a surfeit of allied health workers, where there are not the jobs available for young people in the allied health fields. Yet there are other parts of our country where we desperately need health manpower.

Perhaps we are talking more about distribution of manpower, the distribution of needs, than we are about a surfeit of manpower or personnel. But I do know that this is one of the real problems and we must make our market surveys in depth. We need a good, accurate assessment of the manpower needs in occupational education if we are going to plan well and effectively for the future. We need greater depth in our supervision and greater effectiveness in our instruction in many of our occupational education programs.

Let us admit another factor. We have had difficulty in finding teachers for many of our career education programs, and we have had to compromise sometimes on an instructional staff that is not as effective or experienced as we may wish. The staff may be dedicated and loyal, and its members may try hard, but we must produce effective workers out of our programs. We cannot produce the half-trained person or the ill-trained person to go out and do a job and then expect our employers to keep on employing our graduates. Students must be effectively taught, effectively trained, and perhaps we must pay more attention to supervision and instruction.

Also, we need to turn our attention to the problems coming out of the use of critical facilities. On-the-job environments for out-students in hospitals have been the major source of on-the-job experience for students in allied health, but today the hospitals are finding themselves up against it, too, and are beginning to talk to us about our helping to pay for the clinical experience of our students. This means our helping to pay for the work that hospitals will do in helping to instruct our own students. For a long time we have relied on hospitals to help us bear the cost by offering this kind of experience to our students as a part of our programs. We have turned now to employer groups, to industries, and to commerce and have asked them to provide the environments for on-the-job experience for our students. We must examine these environments very carefully because new problems are beginning to arise. How many students can a hospital take at any one time for instruction on its various floors, in its various departments? Can we make effective use of convalescent homes and nursing homes for this kind of experience for allied health workers? What kind of experience can the small industry or the small

store or the small commercial enterprise provide students? We must turn to all kinds of ways of acquainting our students with the environments in which they are going to work. One environment has already been put into practice as being tried, of course, and that is the simulated work environment. While this may be one answer, it is not the only answer if the simulated experience or the simulated environment is substituted for the real thing. As a preparation for students to go into the environment in which they are going to work as a job experience, simulated environments may be very helpful. But as a substitute, they are not as effective.

These are some of the problems that are coming to us now in occupational education. Money and teachers, working environments, on-the-job experience, supervision, manpower needs, jobs for students, these are some of the problems that we are facing.

Also, there are pressures which come to us in terms of developing the occupational education programs. For instance, there are legislative mandates in career education. The legislature tells a community/junior college that it must offer programs in transfer work, in adult and continuing education, and in career and occupational education. The pressure is there no matter what the budgets may be, no matter what the other problems are, and no matter what hospitals or industries or commercial establishments say about environmental work experience sites. It doesn't matter what the recruitment of students is or how hard it is to get teachers. The mandate is there, and the college must offer occupational programs. This becomes a real problem.

Another pressure, of course, comes from the professional and the employer groups. There are many instances of a professional group in the community or an employer in the community who comes and tells us that he needs such and such because he is a taxpayer, because he is a political heavy gun of the community, because he has clout, because he has pressure. He can put a great deal of pressure on us to develop programs whether we are ready for them or not. So the pressures themselves begin to generate the problems that we have to face. These are the community expectations.

We must have oversold some of the things that the community college does back in those rather twilight days in which we were struggling for existence, in which we had to fight for existence with the universities.

CREATING AND MAINTAINING CAREER MOBILITY FOR THE OCCUPATIONAL EDUCATION STUDENT

J. HARRY SMITH
President
Essex County Community College

First let us take a long, hard look at my topic, "Creating and Maintaining Career Mobility for the Occupational Education Student." One might very well negate creativity by merely requesting someone gainfully employed--even the educator--to create. We may desire an aloofness from barriers created by the use of semantics yet fail to allow for the reaction to our very use of certain words which in many instances are considered mandates or dicta to those with whom we must interact to get occupational education out of the drawing board of the mind. Certain of you may have squirmed when I used the terms "gainfully employed." Well, I really was not specifically referring to the educators, but the oft quoted cliches of how difficult it is to get educators to create merits some further scrutiny.

For many in the field of education, to be asked to create imposes enormous mental burdens; yet many of these same people are noted for their tremendous wills and accomplishments. Hell, the will to survive at my urban politicized institution must be the greatest of all.

Our will has been done in establishing or carrying out priorities of delivering services that were either heretofore unavailable or unknown to people of varying needs.

Remember, these are not statistics but people who have been served, and we should be proud of our accomplishments as we expand our consciousness and priorities.

We must amalgamate the best of what actually is in delivering occupational educational services to the marketplace. I refer to "is" as a form of to be, for so many rich and varying resources are there for the asking. We are not being asked to fashion light from total darkness. When we are asked that creation occur, we may not realize that we negate an existing body of knowledge and resources. No matter how chaotic the mind's eye sees the situation, we cannot really give credence to the madhatters rushing in search of social and economic indicators so that they can indicate a false chaos.

People power can very well tell the final tale of success or failure. But crucial to our mission is the post-identification period. After we have identified the problems and the gaps (as we are now doing), we must then attempt to cope with them.

We have all come into contact with the faculty member, graduate, or undergraduate student who seems to always circumvent yet gets the job done. Although we cannot overemphasize the need for quality people, let us not forget our goal to hire the all-important architects and deliverers of services to the community. In this regard, traditional job criteria should sometimes be laid aside.

In fact, we may sometimes find need for a maverick to get a job done in the face of obstacles, the greatest of which we have seen sometimes coming from our own arts and science oriented colleagues.

When I was asked to create a message relative to creativity, I do have to admit a momentary feeling of omniscience. Unfortunately, the feeling passed and I was again beset with thoughts of the human educator's everyday

dilemma: the narrowing of parameters before boundaries are set. Therefore, at this juncture let me reassert the force that our wills can have in the community and the need we have to avail ourselves of existing ingredients. Let us practice what can be considered a contrast to the song entitled "MacArthur Park" and keep the "cake out of the rain." If constant reaffirmation of institutional community responsibility can foster necessary avenues of delivery of occupational educational programs, then assuredly an alteration of the educational mind set will provide us with momentum along our paths.

When we talk about occupational education, we are really talking about communities; intertwined therein is the continuing question of higher education's obligation to its community. Redefinition of purpose and revamping of priorities are constants.

When a large university or a large college can stand in an inactive posture with the knowledge that there is a lack of quality education in the community, then certainly I think the college is remiss in its obligations to that community. The college is drawing part of its strength, part of its resources from that community. It is part of the reason that the college and its members exist. Therefore, in turn, the college should give something back to the community.

We have to stand ready to posit a forward thrust. We just cannot allow colleges to avail themselves of community resources and give of themselves only when it is in their best self-interest to do so. The average person, when he thinks of occupational education, does not think in terms of the student fully participating in the college program. Unless we change our own mind set,

unless we alter our own approach toward the outlook on occupational education, we are going to continue doing it a disservice. We, too, have to take inventory and we, too, should extend ourselves to see if we can give it the sort of mantle that it so richly deserves.

I represent an institution in an urban setting. Combine a highly polarized, predominantly minority Newark population and its attendant stigmas with the many misperceptions that our suburban residents have about Newark, and you might begin to sense the fear that exists in the suburban community. So as we give occupational education its richly deserved mantle, we must, as urban college representatives, bring necessary educational services to suburbanites. Let me side-step a moment and get to what I feel is a very crucial consideration for educators to make who are community leaders. You may find yourself in a peculiar situation to at first impose your will on various of your constituency. In other words, educationally speaking, you may sense and truly believe a need because of your knowing of pockets of educational deprivation, and you may have to move boulders to get community residents to move in their own self-interest.

In order to get into a particular suburban community prior to the construction of a second campus, we got in touch with the adult education people in the public school systems and in the elementary-secondary systems. Upon approaching them with a program, we said we would like to extend the operation, expand their operation, and enhance ours. In talking with them, we asked how they would like to offer a few college courses as a part of their adult education brochure. They liked the idea. We now have eight suburban communities offering college courses as part of their adult education program. We do not

put out a brochure; they write the brochure and they put out the brochure and they list in their brochure that they offer freshman English or freshman this or whatever course that we are now offering with them. I do not know the precise list, but this has been a money saver for me. Naturally, I estimated the cost before I made a first approach. I do not worry about facilities or their maintenance. The only thing I have to do is send a teacher there, and I generate FTEs (full-time equivalent students) because most of us in New Jersey and in New York area have a student-fund generating budget. That is, the more students we have, the more money we get. It is a terrible way to finance an operation; but we are locked into it by legal mandate.

However, I can generate FTEs in suburban communities without the expenditure of one dime except the salary of the teacher. There is no other overhead. And the schools are happy to have it because it creates a greater interest in a segment of population that they were not touching. They were not touching the person who had a couple of years of college or who had finished high school and wanted to perhaps try some college courses before putting both feet into the water. Therefore, I think there are many opportunities to do this, not only in the area of allied health but in other fields. We need to confirm these and other successful steps by improving our dialog with all entities that make up public education: elementary, secondary, and collegiate. This makes the "mobility" part of my paper's title come into being. Without this dialog and the constant reaffirmation commitment, mobility fast ceases to exist.

Let me look at another characteristic or lack of it that has impeded perhaps both the delivery of services and mobility. Our present financial

crunch and loss of guts all militate to the detriment of educational expansion. I do not think educators have done enough in the way of going to the marketplace with a definite statement as to the reasons, the "whys" and the "wherefores," that they have to have to seek support at a certain level. We are so completely defensive about our positions, we become incapable of spelling out some of the substantive gains that we have brought to the community.

Now I believe that in occupational education and in allied health, where there are some extremely high-cost programs, I would rather not have any more allied health students, and I have put a clamp down. I have to put a clamp on them because I have got to stay within my institutional budget. The average cost per student at our institution runs approximately $1,850 a year. The cost per allied health student runs me about $3,200 a year. That means that the state is funding me at the cost of $1,850, and for every allied health student I am taking a real beating. It is a disproportionate cost, and somewhere along the line more thought and more action must be directed toward differential funding.

Allied health and other such programs will continue to suffer until we get the funding agencies to engage in differential funding. When we get into programs like radiologic technology, we certainly are working at a very high cost that is well above the average cost per student. If we can, we should force the funding agencies to fund our nursing students based on what it costs us to actually have a nursing student, not what the state grants for an average FTE.

I do not fund a nursing student based on what it costs for me to take someone through social science and make a social worker out of them. When I am hit with a small student-teacher ratio as a basis of the clinical experience that is mandated in the course, it is just inconceivable that I remain silent on this issue.

One of the things I would like to see in allied health is the development of some solid, bona fide evening programs. Let us take an LPN who has a daytime schedule and perhaps a family to support. She is totally locked out from any career ladder because there is nothing happening after four p.m. to cause her to be upgraded and become an ADN and a RN. One of my contentions is that we educators are grossly guilty of the under utilization of space and personnel. But I do not think that we should have hospitals that close down at three or four in the afternoon with the high cost space in the hospital not in use from approximately that time until the next morning at seven or eight o' clock. Of course, there is no clinical work done in the evenings. However, there are people who need the opportunity to get in for further study. What I am suggesting will probably cause problems with the hospital administrator and will cause problems with hospitals in general and with doctors in particular.

I do not see why we cannot talk of two shifts in a hospital. Why must all things cease at about four or five every day? Who says that an X-ray must be taken during the daylight hours and not in the evening? Who says an operation cannot be performed at six or seven at night? I look at the scheme we are now in, and I feel that there is a terrible amount of under-utilization

of much critical space both in education and in hospital work. I know that it can be worked out, but it will be only after quite a bit of strife and turmoil in many quarters. There is a similar problem of hours not only with the nursing programs but also with other technical programs that relate to certain fields.

I had the misfortune of having to have some major surgery. I guess all of us have been in the hospital for a period of time. The first night during my recovery, the nurse gave me a sleeping pill about nine p.m., and about two in the morning she woke me up to give me another pill. Well, this went on for two nights before I got my wits about me. The second pill, the one she was giving me at two, I had to have every twelve hours. So she was giving it to me at two in the afternoon and two in the morning. I thought I asked a rather sensible question of the nurse: "Why can't you give me the pill at seven in the morning and at seven at night?" She said, "Well, the doctor said every twelve hours." That bugged me and I just could not figure why I was presenting the problem to her. Well, we had a heated argument, a real hassle, and it took me two days to get to my doctor. He said, "Hell, all I want you to do is take it every twelve hours." Eventually, I took it at seven in the morning and at seven at night. But people who go to hospitals and get a pill every twelve hours or so still get a sleeping pill about nine and then are awakened in the middle of the night to take more medication. However, I do think that we have moved down the pike quite a bit. Although my anecdote typifies rote thinking that we as educators must begin to modify.

I am a sports fan and years back when the New York Yankees were winning pennant after pennant, they used to conduct a morning session and an afternoon

session during spring training. They trained at St. Petersburg, Florida. The St. Louis Cardinals also trained at St. Petersburg and they hired a new manager one year. The manager looked at the Yankees and he looked at the Cardinals, and then he went into the clubhouse and he told the fellows in the locker room, "I have watched the Yankees. They are the world's champions. They have won pennant after pennant, and they have a morning practice session and an afternoon session. From now on we are going to have a morning session and an afternoon session." There was a long silence. Everybody sort of knew what he was trying to say, but then Pepper Martin spoke up: "Boss, you can have all the workouts you want, but ain't nobody ever won the Kentucky Derby riding a jackass."

Come to think about it, we have sort of put ourselves in that situation. We do not come out of the starting gate with a thoroughbred. We just want comfort and we take the good easy ride. So much is contingent upon the attitude we take toward the person that we are bringing in to do the job. We should get a thoroughbred. We should get someone who is going to go out and dig up and bring in ideas. He must give a real hard effort and a sense and feel of purpose that can motivate us some. It is terrible when we think that the only reason we are doing what we are doing is because of our high purposes and ideals and that actually there is no one down along the line whether in a horizontal or vertical position who we believe could contribute something to make us more motivated.

I think I am motivated because at our rather young college that did not start until 1968, we have an FTE of about 5,400 and a part-time enrollment of about 7,500. We are still growing. We have a $31 million mega structure going

up, and by 1980 we hope to have an FTE of 10,000. This kind of figure is great, but we have other kinds of figures. We had the distinct pleasure of having a young girl who worked for the Prudential Insurance Company in Newark. Now this is occupational education. She said she got tired of working for people who did not know as much as she did; so she finally came to Essex County College. We gave her financial aid. Her parents live somewhere in Middlesex County, but she was off on her own working and living in Newark. She finished at Essex two years ago and went to Drew University in Madison, New Jersey, and we felt quite elated when we found that she is one of the twenty-nine people in the United States who has been awarded a Fulbright scholarship and will be attending the University of London School of Economics. That is motivation. We can all stand around and not be touched by the fellow who comes in, makes it in a rather pro forma way, and does not have any real goal or objective. However, when one hears about a young lady who has probably worked as a secretary or clerk for three or four years and today is going to be a Fulbright scholar or is a Fulbright scholar, one understands motivation. And that is occupational motivation because what was she doing at Prudential? She was not in a supervisory capacity. She was just one of the girls in that ant pile out there.

We have to do a lot of homework, and we have to work particularly hard prior to any concerted effort in order to diminish that which must be done once the project begins. We have to develop our own scouting techniques. We must, in the old boy scout way, be prepared. We have to do our homework. I do not think that we often have extended ourselves fully. I do not think we have done it with open arms reaching for people from other entities. Whether

it is the vocational efforts here or the secondary efforts there, or whether it is a technical institute here or something of any other nature, we have to have people develop the confidence in us that we seek from them.

I do not want to close my statement to you by starting out with "to conclude." The reason is that I think it is too early in the game to draw a conclusion. My thoughts on the subject of occupational education are going to be buffeted about and subject to change as are yours. Conclusion in my mind indicates a certain finality, and I am sure that agreement could be had from those who have delved into the subject of occupational education that we still have a long row to hoe.

But I would like to bring something to mind that most educators are fairly used to dealing with and that is the bureaucracy and compartmentalization that can so quickly spread like tentacles and suck the vitality from programs such as the one about which we have been talking. Compartmentalization wreaks havoc and creates artificial lines of demarcation that can prove devastating. Occupational education--to sustain its mobility--must interest and interact to ward off intimidation and internecine warfare.

CREATING AND MAINTAINING CURRICULUM FLEXIBILITY

Expanding Opportunities in Allied Health Careers--
Programs for the Occupational Education Student

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One of the exciting characteristics of education is that it is concerned with the future. In allied medical education, we are preparing people for employment in the future. Allied medical education begins with the plans we are making now for the students who will be learning during the 1973-74 school year and probably the 1974-75 school year, to develop the proficiencies they will need to work at health occupations in 1976 and the years that follow. So we are thinking now about the education students' need to work in 1976--the future. In answer to the question "What kind of future?", each of us would perhaps answer, "Well, one thing I know: it's going to be different!" More than that, the changes are coming along faster all the time.

Popular interest in this accelerating rate of change made Alvin Toffler's book, Future Shock, a best seller.[1] He provides many examples of the fact that things are changing more rapidly all the time. Toffler writes about duration--the span of time over which a situation occurs, and he emphasizes the increasing rate of change. Toffler disagrees with those who predict a future of uniformity; Toffler reminds us that one of the characteristics of the technology of mass production is diversity. He says our super-industrialized society is producing the greatest variety of unstandardized goods and services with diversity costing no more than uniformity. He

describes the bewildering choices and the problem of "over-choice"; some examples are, a supermarket with thirty-five kinds of honey and the options offered by automobile manufacturers.

The diversity is becoming characteristic of education. It is not generally realized that the medical school has been made into a kind of supermarket. Allied medical education is moving swiftly toward diversity. Maximum individual choice is the democratic ideal. My guess is that in the future no two allied health students will move along the same educational track. Computers are scheduling more flexibly with wider ranges of course offerings and more varied clinical educational experiences. The multi-campus university has become routine, and study is being decentralized to the individual study carrel in the library or the multi-media audio-visual study center and even the students' own rooms in the dormitory or at home. Just as students formerly borrowed books, they now borrow hard-copy readouts from computerized information retrieval systems; students borrow sound and video tapes, materials from the language laboratory, and single-purpose multi-media instructional units. Study can continue at any hour and any day of the week. The whole point is to help each student to advance at his own personal pace.

The educated man will be the one who has learned how to learn. The AMA Council on Medical Education is concerned only with the quality of that education for an allied medical occupation. The education program can be based in public or private schools, colleges, universities, vocational and technical institutes, in schools run by corporations or the military services, or at home. I might add that AMA approval of educational programs by the

Council on Medical Education and collaborating organizations encourages innovation and experimentation by providing the security of understanding, cooperation, and support.

We are interested in and committed to creating and maintaining curriculum flexibility, improving programs for the occupational education student, and expanding opportunities in allied health careers. To that end, I would like to comment briefly on seven subjects:

1. a master plan for allied health education
2. common courses and career mobility
3. continuing education
4. equivalency and proficiency examinations
5. area and institutional program evaluation
6. military allied medical education
7. the campus-like medical services area of the future

1. A Master Plan for Allied Health Education

Allied health education and mobility would be facilitated by articulation of the many kinds of settings and institutions in which education is being provided. To this end a kind of master plan is needed to define the qualities of the several kinds and levels of education so that credit is given for satisfactory education; for example, schools of allied health in four-year colleges and universities should give appropriate academic credit for the relevant education completed in two-year community or junior colleges.

Perhaps it would help to start this discussion chronologically. Allied health education began in hospitals and other clinical settings, and most

allied health educational programs continue to be based in hospitals. More than 2,000 of the 2,700 AMA-approved allied medical educational programs are based in hospitals and other clinical settings.[2] Allied medical occupations are those allied health occupations which work with and/or under the direction and supervision of physicians in providing services to patients. Clinical instruction by currently competent clinical instructors in clinical settings is necessary for learning to provide services to patients.

During the last three decades, there has been an explosive growth in higher education in this country, stimulated in part by the return of millions of veterans after World War II. A substantial part of this growth has been the rapid development of junior or community colleges which welcome all who want to learn and who are nineteen or more years old (the average age of junior college students is twenty-seven!). Note that junior colleges offer educational programs for a hundred or more occupations, and just a dozen or two of these are likely to be health occupations. That is why the junior college president is not eager to gather the health occupations programs into a school of allied health that would pressure for a disproportionate share of the available resources.

Meanwhile, the four-year colleges and the universities have developed schools of allied health, and the Association of Schools of Allied Health Professions was organized to provide national leadership for this important movement. As usual in the health and medical professions, there is some lack of consensus on terminology; "allied health" is not an acceptable term to

everybody; some prefer "College of Health Related Professions," for example. Clustering the various allied health professions into a school or college serves to focus discrete elements into a stronger, more coordinated program.

It makes sense to budget money for higher education. Colleges and universities contract with hospitals and clinics to provide clinical instruction to allied health students. Such hospitals are affiliated with the college or university; the college grants the students academic credit for the instruction provided in the clinical setting. Clinical instructors should be granted appropriate faculty appointments with or without pay. We should make sure that the college does not keep all the tuition when the hospital provides the instruction. We should make sure that the students are not used to provide cheap labor. One major hospital studied the costs of education provided by the hospital and concluded that the services provided were more than equal to the costs!

We should not talk about hospitals going out of the business of education; hospitals will always be needed to provide clinical components of education for allied medical occupations.

Junior and senior college people should and do recognize that important allied health programs have developed in other settings:

High Schools. Health careers recruitment is directed to grade school, junior high school, and senior high school students. A few high schools are pioneering outstanding educational programs to prepare students for entry-level jobs in health occupations, such as working for practicing physicians and working at jobs in hospitals and clinics.

Vocational Schools and Technical Institutes. A major allied health program is conducted by the vocational/technical education people who are now calling it "career education." The American Vocational Association and American Technical Education Association are among the leading associations providing national leadership, and Miss Helen K. Powers in the Office of Education is among the leaders in the program of federal support which assists state vocational/technical education programs.

Military Installations. Military medics are taught at Army, Navy, and Air Force bases in a military allied medical education program that is a major component of the total education for allied health occupations in this country. The Surgeons General of the Army, Navy, and Air Force appoint the officers in charge of these programs to a task force on military allied medical education, a subcommittee of the AMA Council on Medical Education's Advisory Committee on Education for the Allied Health Professions and Services. A Compendium of Military Allied Medical Education is available. The objective is to blend civilian and military allied medical education.

Proprietary Schools. As tuition increases at tax-supported as well as private colleges and universities, the expenses of higher education become increasingly obvious. An objective look at higher education (by the courts, for example) results in the observation that the quality of education is the point, not whether the enterprise is motivated by a profit. The AMA Council on Medical Education and collaborating organizations accredit allied medical educational programs at proprietary

schools because the medical and health professions are interested in the quality of educational programs, not the method of funds. Ethical practices in education are necessary, of course, but they apply to all: proprietary, private and public schools, and colleges.

The four million people who work in health occupations were educated in some of these kinds of settings. We should admit it to ourselves and facilitate student mobility as they make their choices to prepare themselves for health careers.

This calls for a national master plan for allied health education that provides for acceptance--academic credit--for education provided in any and all of these settings. All the usual academic standards must apply: level of education, completion of work, quality of student achievement, etc. In California,for example, academic credit earned in junior colleges is accepted by the state colleges and on the nine campuses of the University of California.

But the usual academic restrictions must be reexamined; the college should not say, "We do not give credit for non-traditional education." We must develop respect for all the settings in which allied health education is provided effectively. Education could be compared to a ratchet: appropriate education should be recorded and credited in a cumulative transcript. The student should know that each major educational achievement is acceptable to the higher education community. In other words, academic credit should be given when it is earned, and colleges and universities should learn to accept appropriate credits earned in other kinds of institutions.

2. Common Courses and Career Mobility

The Council on Medical Education of the American Medical Association strongly supports the concepts of "career ladder" and "career lattice" for the health professions. In an effort to promote such vertical and horizontal mobility, the council seeks the cooperation of the associations of health professionals, with whom it collaborates in the process of accreditation, and those institutions sponsoring health-related educational programs--two and four-year colleges and universities, medical schools and schools of the allied health professions, medical centers and teaching hospitals, vocational/technical schools, proprietary institutions, and the military.

Professional associations and licensing and credentialing bodies should remove unnecessary, purely formalistic obstacles from the paths of those striving to progress from lower to higher levels of knowledge and skill within the same general specialty area. Adequate account should be taken of what has been learned through non-traditional educational forms and by experience, and equivalent training and education that was acquired in pursuit of other health-related occupations should be recognized as satisfying fully or in part registry or other credentialing requirements within the profession.

Those who will work together as a health care team should, whenever feasible, learn together. The implementation of a core curriculum can be a positive step toward achieving this goal and should take place in both the pre-clinical and clinical components of the educational process. Health career training programs can benefit from an initial "core" educational experience with frequent opportunities for choice of a specialty area.

Organization of technical training by clusters of related occupations preparing an individual to be a specialist in two or three areas may be one means of avoiding training a person in an excessively narrow and restricted area of knowledge and skill. A health science core curriculum can provide a sound educational foundation for many categories of allied health professionals and make it possible for a student to adjust his career choice within the health professions with a minimum of lost time and effort. All types of health education institutions and program directors should be thorough but open-minded in evaluating transfer credits from other educational programs and institutions. It should not be required automatically that equivalent courses satisfactorily completed in other educational programs be repeated.

If the career mobility is to become a reality, it will be because of the cooperation and ingenuity of associations of health professionals, educational institutions, and all types of health care delivery institutions. To facilitate this, the AMA Council on Medical Education's Advisory Committee on Education for the Allied Health Professions and Services has a Subcommittee on Common Courses and Career Mobility. James P. Steele, M.D., is chairman; the members include Richard A. Ament, M.D., Sister Anne Joachim Moore, Martha Phillips of the VA, and Daniel R. Thomas, of AHA; and John J. Fauser, Ph.D., is the staff secretary.

3. Continuing Education

Most professionals ricochet from education to a job to education and back to a job. We oversimplify when we think that students graduate and then get

jobs in the occupations selected. Actually we go to school, we work, we return to school, we change majors and minors, we change vocational objectives, and even when we are employed we might find that for some professions, to get ahead one must get out.

Our formal as well as our informal education continues for life, especially in the health professions. Education is being restructured so that some students can work while they study, and others can continue their education in short and long periods of time. Junior colleges provide one kind of example of this. That is, most community colleges are open evenings and weekends.

National programs for continuing education constitute an increasingly effective means for learning to communicate as members of health teams. National, state, and local programs for continuing education help meet this need among allied health professionals.

All the members of the medical care team, including the physician, are engaged in work which requires them to keep up to date. Furthermore, education as well as experience helps to develop competencies which qualify allied medical workers for more responsibilities, and this may lead to promotions.

A person gets ahead in the health occupations by education and experience which develop increased competency for service. Some high school graduates get a job in a doctor's office, a clinic, or a hospital and are given opportunities for some formal education and some on-the-job training. Sooner or later some of these people decide to go back to school. Quite a

few people work and then go back to a vocational/technical school or a junior college. Some students earn certificates on the completion of short courses; others complete two years of junior college work and earn an associate degree. More young people are going on to complete four years of college work and earn a baccalaureate degree. They might obtain a job in a health facility and later go back to some university for graduate work to earn a master's or a doctor's degree.

The concept of lateral and upward mobility is applicable to students whose formal education is interrupted. Medical schools average up to ten percent attrition; what happens to medical students who drop out of medical school? Why don't we recruit more dropouts from medical schools to educational programs for the allied medical occupations? I would like to see us give more attention to cumulative levels of education and experience, like rungs in a ladder, so a student could climb as far and as rapidly as time, money, and ability would permit.

Recently I have been hearing more references to the four-day work week. I do not believe in it. I would much rather see us retain the five-day work week, but encourage the employee to spend one of the five days continuing his formal education. If we spent one full day each week continuing our formal education on the campus and in the clinical setting, we could earn enough academic credit to qualify for an advanced degree. Under such a plan employers could require professional employees to earn an additional graduate degree each decade,and non-professional office employees could earn baccalaureate

degrees. This is the plan: four days in the office and one day on the campus, all as part of the job. I think it is much better than the four-day work week.

Because of the need for assuring continued competency and in view of the rapid pace of technological developments within the allied health professions and services, the need and demand for effective, well-organized programs of continuing education for allied health professionals has become increasingly apparent. Although all professional organizations provide opportunities for continuing education of their membership, it is felt that greater emphasis should be placed on an inter-disciplinary approach based on the components of the health care team.

To help make this happen, the Advisory Committee has a Subcommittee on Continuing Education. H. Robert Cathcart is chairman, and Warren G. Ball, D.D.S., is staff secretary. The other members of the subcommittee are Betty Byers, MT (ASCP)NM; Larry Gessner, CORT; J. Rhodes Haverty, M.D.; and Rosser L. Mainwaring, M.D.

The subcommitee has defined continuing education as a formalized learning experience designed to expand the knowledge and skills of allied health professionals who have completed preparatory education. As distinguished from advanced education, continuing education courses tend to be more specific in nature and of generally shorter duration. The subcommittee also determined that in-service education is regarded as a program administered by the employer, designed to upgrade the knowledge and skills of employees, and essentially related

to specific job assignments. The subcommittee has identified the following sources of continuing education for allied health professionals: professional organizations (medical specialty and allied health), school of allied health professions, medical schools, voluntary health agencies, regional medical programs, hospitals, and commercial firms.

In order to determine the current status of continuing education for the allied health professions, a number of surveys are to be conducted. Among these will be surveys of professional organizations and educational institutions, as well as agencies involved in certification and registration. The subcommittee will also explore the development of appropriate incentive mechanisms similar to the AMA Physician's Recognition Award. Regarding the financial aspects of continuing education, the subcommittee supports the concept that the continuing education of allied health professionals should be identified with the legitimate costs of patient care.

4. Equivalency and Proficiency Examinations

Some programs take off like a rocket. At first there is a lot of noise and smoke but no movement, and then there is a slow beginning of movement. That is how it was with seat belts and the military medic, and that is how it seems to be with core courses. Sometimes that is how it seems to be on the subject of equivalency and proficiency examinations.

Nevertheless, there is a lot of interest in the problem and in its solutions. To focus AMA participation in such work, the Advisory Committee has a Subcommittee on Equivalency and Proficiency Examinations. Len Hughes

Andrus, M.D., is chairman, and the staff secretary will be John E. Beckley, Ph.D., who starts work June 1 as assistant director of the AMA Department of Allied Medical Professions and Services. Dr. Beckley's doctorate is in higher education administration, and he was head of the Bangor campus of the University of Maine.

An agglutination of competencies and involvements is taking place which is likely to make this a very productive activity during the coming years.

5. Area and Institutional Program Evaluation

Nellie May Bering, MT(ASCP)NM serves as chairman, and Warren C. Ball, D.D.S., is secretary of the subcommittee on Institutional Approach to Program Evaluation.

The subcommittee was formed in response to growing recognition of the need for development of a multi-disciplinary approach to evaluation of educational programs for allied health professions. At institutions conducting three or more teaching programs within the allied health professions, it is anticipated that concurrent surveys by expanded teams, composed of representatives of each occupational area involved, will be appointed.

This procedure will substantially reduce the frequency of site visits to hospitals, colleges and universities without decreasing the depth and scope of individual program evaluation. Separate survey reports are to be prepared for the consideration of the appropriate review bodies with each program to be evaluated on the basis of its own merit.

Among the alternative mechanisms currently under consideration by the subcommittee are the following:

a. Participation in institutional surveys conducted under the auspices of regional accrediting body. This would involve an expanded survey team including at least one and possibly two representatives of each of the professional program areas subject to evaluation. There would be no additional direct expense to the educational institution beyond the normal fees of the regional agency. Individual program evaluation reports would be forwarded to the regional accrediting body for inclusion in its institutional survey reports as well as to each of the appropriate review bodies for consideration and preparation of recommendations to the AMA. It is understood that institutional accreditation would not be contingent upon individual program approach and that each program would be evaluated on the basis of its own merit. Survey schedules would be largely dependent upon those of the regional agency.

b. Institutional survey of allied health professional programs with regional accrediting agency representation. This alternative involves no attempt to schedule site visit evaluations concurrently with those of the regional association. However, a representative of that organization would be invited to participate actively. Invitations could also be extended to other accrediting agencies within the health professions (i.e., American Dental Association, American Dietetic Association, AOTA, APTA) to schedule simultaneous program

evaluations. Evaluation reports would be submitted to both the regional accrediting body and the appropriate review bodies for consideration, and again individual program approval would not be contingent upon approval of other programs conducted by the educational institution.

c. Multi-disciplinary of institutions with three or more programs within AMA accreditation purview. This alternative is thought to be appropriate for hospital based programs as well as those of educational institutions offering a small number of allied health professional programs. It involves only an effort to coordinate the schedules of various review bodies in arrangements for concurrent program evaluation with minimal inter-disciplinary involvement. It is not anticipated that regional accrediting body participation would be indicated.

6. Military Allied Medical Education

More than ten million Americans receive their medical care from the Army, Navy, and Air Force medical services. Education and training for military allied medical workers demand the same standards as those for the civilian components.

The objective of the Department of Defense-AMA Subcommittee on Military Allied Medical Education is to make military and civilian educational programs even more effective. This subcommittee recommended the following policies which have been adopted by the AMA Council on Medical Education: 1) the

council requests all accreditation review bodies involved in allied health education to initiate accreditation activities through a single designated contact office in each branch of the services; 2) the council expressed its willingness to accredit an allied health educational program conducted by a military service rather than at one specific location; and 3) the council will refer to the appropriate review committees for their consideration that survey teams and review committees give special attention to the fact that the clinical portions of military allied medical educational programs include unusually extensive, formally supervised,clinical educational experiences.

Other goals established by the subcommittee include development of common terminology, correlation of curricula, transfer of credit, inter-organization communications, and qualification of military allied medical personnel for registration and certification in the several allied health areas. One of the major concerns is the transition of the military medic into the civilian health team.

A compilation of the activities and interests of the subcommittee and other information useful to former corpsmen, professional counselors, potential employers, and other allied health groups including boards of registry is revised regularly and available upon request. This Compendium of Military Allied Medical Education can be obtained by writing the AMA Department of Allied Medical Professions and Services.

7. The Campus-like Medical Service Area of the Future

When you stop to think about it, you and I are satisfied with only one quality of medical service: it must be right. For example, when someone

draws blood, it must be done correctly; or when someone determines blood type, it must be done exactly correct. What is important is not just that the blood be typed; it must be done correctly.

Now I would like to give special emphasis to my point on quality patient care. Physicians, nurses, and allied medical professionals participate as a team in providing the best possible diagnosis and treatment for the patient. Ernest B. Howard, M.D., executive vice-president of the American Medical Association, says it like this in the seventh edition of the AMA paperback book titled Horizons Unlimited :

> The two fields--medicine and careers allied to it--are inseparable. They are equal partners working together in a common cause of the highest order--making life healthier, happier, and more productive for each of us.[3]

When I look at the delivery of services by business and industry, I cannot help but be impressed by the efficiency and cost-consciousness of businessmen as well as by the excitement of newer and better ways of doing things. We drive into a huge new shopping center, and it is easy to find a place to park. We drive to a new hotel or motel and find satisfying services to meet our needs. We drive into a Standard or Texaco filling station (on any corner of the United States), and our credit card answers all questions of who we are and how we propose to pay the bill. New products and new services are complete in the marketplace of our free enterprise system.

I like that, and I would like to see the management competencies of big business applied in partnership with the medical profession for the more efficient delivery of more health services. I think we have a management

problem in health, and I would like to see top level managers of our free-enterprise system solve it.

I would like to see an agglutination of the health facilities and personnel of a community in a campus-like health center surrounded by parking space. Helicopters as well as automobiles would improve the transportation of trauma cases as well as other medical emergencies. I would like to see a front entrance and reception area open night and day 365 days a year with the civilian equivalent of the military Triage: the sorting out of medical and dental cases to determine priority of need and proper place of treatment. I would like to see an identification card coded to computerize information to take the place of the reiteration of one's personal health history and the need for hospitalization to qualify for insurance payments. I would like to see a one-story motel-like facility for out-patient and admitting services and office and clinic space rented to physicians and dentists practicing privately. You can add much more to this picture, and of course much of this is already happening at places like Baylor, the Cleveland Clinic, Mayo Clinic, and Kaiser Permanents.

Such campus-like medical service centers, renting office and clinic space to health departments and voluntary health associations as well as to practicing physicians, would be a splendid location for the clinical parts of allied medical educational objectives: members of the health care team who are going to work together would learn together; medical students could have clerkships and other clinical experiences in doctors' offices and in group practice settings as well as at the episodic and really a typical teaching

hospital which is normally used today; students could more readily work part of the time and learn the rest of the time; and education could become the life-long continuum which is really needed in the health professions partly because physicians could get away to spend time on continuing their formal education without neglect to their patients.

Curriculum flexibility must be created and maintained because it expands the programs for the occupational education student and expands later opportunities in allied health careers.

This calls for:

1. A master plan for allied health education in which credit is given for what the student has learned to date--academic credit by institutions of higher education, and recognition of proficiency by registries and other credentialing agencies.

2. Common courses so that as much as possible students for health careers will learn together, at least in some courses, and career mobility is facilitated for employers as well as employees. After all, half the hospitals in this country have less than 200 beds.

3. Continuing education--formal higher education--throughout our professional careers, as a condition of being professional.

4. Equivalency examinations so entering students can be examined and given credit for what they have learned which is equivalent to

portions of the subject matter for which mastery is required; and it calls for proficiency examinations so job applicants can demonstrate that they have acquired the proficiency required for the job if they do not have the usually required piece of paper.

5. Area and institutional program evaluation which should be used to encourage curriculum flexibility.

6. Blending military and civilian allied medical education in ways which benefit from curriculum flexibility and enhance the job opportunities of graduates.

7. Allied medical education for teamwork, possibly on a campus-like medical service area in future decades. No, this does not mean a team in which we are all chiefs who work as associates but a team in which responsibility is fixed, determined in the best interests of the patient.

Creating and maintaining flexibility is why we work, and that is one reason we are here. We do not work to perpetuate rigidity; we work for the future, a flexible, responsive education in the public interest.

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LIMITATIONS TO CURRICULUM FLEXIBILITY: THE REALITIES OF ACCREDITING AND CREDENTIALING

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I am far more interested in what we can do about limitations to curriculum flexibility than I am in spelling out just how bad these limitations are. Many of us have experienced setbacks, but we have a new advantage in our time in dealing with the problem of limitations in curriculum because of either the licensing, accrediting, and/or credentialing. A couple of weeks ago an analysis was done of both the state and federal budget situation in education for the health fields. Bleak as it is, we were looking for bright spots. As you know, the fiscal 1974 budget from the federal government is roughly half of what it was in fiscal 1972. For instance, allied health is zero-budgeted in the fiscal 1974 budget, from a total of $30 million in fiscal 1972. Public health schools are zero, down from $19 million. Also, the nursing budgets are cut to about a third from what they were in fiscal 1972, from $140 million to $52 million; about the only people who do not get cut out are doctors, dentists, pharmacists. Podiatrists, veterinarians, optometrists are all zero-dollar budgeted as well. It is indeed a pretty bleak picture.

In the state budget, the same kind of thing is happening. The Board of Higher Education cut the proposed monies for institutions from about $900 million in February to $647 million. The governor claims he will not approve that. He wants only $601 million spent, so that staff of the Board of Higher

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Education must cut $46 million. One of the first places the staff chose to cut was $10 million out of our funding for health fields in the non-public institutions. This is bad enough, and coupled with it is the possibility that within the public institutions health may not do anywhere as well. The University of Illinois has already said that even though health raises are spelled out in suggestions from the Board of Education, the health fields will not be increased. At the meeting of the Health Education Commission the other day, the university showed the kind of cuts it is going to make in its health programs if the budget does not come up higher. They are not going to increase health at the expense of everything else. They will raise faculty salaries and not cut out English or Sanskrit or some other department. They are going to make this fight; they will probably lose, but so will health and health fields.

Of course, the vocational education veto will also prevent about a million dollars in aid for allied health from coming into this state through the Vocational-Education Act.

Yes, it is a pretty bleak situation, but one of the bright spots is the fact that being forced to look at how we can get the most of education dollars, we will be in a strong position to say that we want limitations removed, <u>except those limitations that have to do with a good education and with the protection of the eventual user of the product</u>. I think this is analogous in many respects to the reason we have had so much progress in health manpower and in many other kinds of manpower during the last twenty years. We have had a shortage of skilled people and have, therefore, looked for innovative ways of getting those skills without necessarily doing what we have always done.

We are certainly going to live with budgetary restrictions through the period of the 1980's, regardless of the administration. The result should be a militant movement, which I hope we will be part of. We should make certain that we do not waste money keeping people in classes in which they do not need to be. We should eliminate redundant programs, consolidate schools, and eliminate obsolete practices and ideas in law or in the credentialing process, as well as in the schools themselves. This terrible business of not having enough money is going to help us create and maintain curriculum flexibility. All that was by way of preliminary to the subject I have been assigned.

I have been on the Health Education Commission of the State of Illinois since the commission's inception five years ago, and it has programmatic approval over everything in health schools from the medical on down to the bottom end of junior colleges. In all the new programs that have come into being in the last five years, I know of no case where anyone was prevented from teaching anything he wanted to because of the legal or credentialing kind of restriction. Teachers sometimes taught things that they did not want to teach, but I know of no one who was not able to use a reasonable amount of flexibility and innovation if they thought it was necessary for the education of their people. There are limitations in having to do things we may not think necessary, but not in the area of doing things we want to do, if we exercise a sufficient amount of imagination. And we have had some amazing examples of people using their imagination.

There is a whole folklore concerning the restrictions of law, or the restrictions of credentialing agencies. A few years ago I had people running

seven-hundred-bed hospitals tell me it was illegal not to have a registered nurse in the operating room. This was a worry in developing operating room tech programs. We searched every legal area we could think of: the fuzzy regulations of the Committee of Nurse Examiners in the State of Illinois, the Illinois Hospital Act and all of its regulations, and the standards on accreditation of hospitals. All said that nothing could be further from from the truth. The Joint Commission on Accreditation did not care who they were using in the operating rooms, provided, of course, they were using surgeons, as long as the surgeons had made rules concerning the personnel and its qualifications. The ability of the personnel should be considered more than the degree.

Finally, we thought about the Feds and Medicare, since these are the only areas (the Social Security Act, Medicare, and Medicaid) in which the Feds enter into these kinds of regulations. In the alternate Medicare regulations for hospitals which were not accredited by the Joint Commission, it was pointed out that there has to be an RN in the operating room when people are doing surgery. But there is not a single hospital in the State of Illinois that is not so accredited. Yet we had people telling us that it is illegal and, therefore, we couldn't staff full operating rooms with OR-Techs, despite the fact that a great many nurses do not want to work in the operating rooms. This is the kind of myth that grows. We have many more.

When I was younger and dumber, I took the vocational education people's word for it that we could not run certain kinds of medical or dental assistant training programs in high schools because it was illegal in the State of Illinois under the regulations of the Bureau of Radiologic Health to have

anyone under eighteen anywhere near an X-ray machine. Because I was younger and dumber, I went to all the trouble of getting a pet county medical society to put through a resolution at the state medical society's annual convention asking that something be done about this. (Until recently, when the Illinois State Medical Society said jump, the director of the Department of Public Health was in the air before he asked how high.) We got action immediately and found that the regulations were the same as the Federal Radiological Health Regulations, which had certain exposure maximums. It was perfectly possible for people who understand these things to work out educational programs in which the students could come into proximity with X-ray machines and therefore would be able to train to get a job.

This goes on and on. There is nothing in our state law which says that you have to use someone who has a Master of Science in Nursing as one of the persons in charge of a course in a community college. In fact, there is nothing in the law which says anything about the faculty. All it says is that the department has the right to designate approved education institutions. Everything else is in the regulations. Yet we have people say, "It is in the law."

People say that it is in the law that an LPN cannot be "in charge." The only mention of an LPN's relationship in the law is that she must work under the direction of a registered nurse, a physician, or a dentist. Still we have had interpretations of that law by staff members of the Department of Administration and Education which say that it is illegal for her to be in charge.

Most of the hospitals down here are considerably under one hundred beds, and at night often the person in charge of the entire hospital is an LPN. Of necessity, there just are not enough RNs. But, at the same time, we have people telling us that we cannot run charge nurse continuing education courses for LPNs because it is illegal. We have had people tell that to a junior college which is attempting to meet community needs, and fortunately first of all the college called us. We then lined up our lawyers, and got ready to go to court and point out that the hospitals are forced to put these people in charge and yet the department is trying to prevent us from giving these people courses so that they can do the job. We were ready to go, and then the junior college did not have guts enough to go to court with us!

So there are all these myths. Consequently, in terms of maintaining and creating curriculum flexibility, one should first of all reexamine the statutes and regulations! Unfortunately, though, a real problem in doing this is the fact that most of the college health occupations faculty are graduates of the guilds themselves, and many have either absorbed such folklore or want to believe the guild standards instead of understanding what is really needed in a good product of an educational program: someone who can handle the job once he gets out of the program. The question is this: what can one do within the framework of existing regulations as they are presently interpreted? Just how bad are regulations in terms of the law?

I serve on the State Advisory Council for Comprehensive Health Planning, which is the federally mandated comprehensive planning body. A couple of years ago, because we were interested in how far we could go within the framework of existing laws to get as much curriculum flexibility, career mobility,

etc., in utilizing manpower resources, we hired a young lawyer out of Nathan Hershey's shop (the Institute of Health Law at the University of Pittsburgh). His assignment was to look at the regulations of the fifteen boards which administer the health licensing acts in the state of Illinois, and see whether the regulations really had a solid base in the statutes themselves, or whether the regulations had lots of misinterpretations.

Unfortunately, he could not carry out the assignment because the regulations were either extremely nebulous, nonexistent, or changed with each meeting of the particular committee or commission or board which interpreted the law. In many cases there were no regulations at all for him to compare with the statutes. The result of our study showed some horrible stuff created within the department without very much basis in law. The department responded admirably, creating a new position for coordinating all the health licensing divisions and trying to make some sense out of the regulatory end of the process. Unfortunately, the man hired was dropped with the change in administration, but hopefully the new administration will carry this forward. We need a health division of the department to formulate decent regulations which all of us can read and adjust our education and other programs accordingly. Everyone interested in flexibility ought to make certain, even demand, written copies of the regulations. He must never take somebody's word for it.

There are some realities. There are realities of time, both in the credentialing and licensing processes, hours, classes, clinical time, years, etc. Fortunately, we are on a trend away from this. This is subject to change because, except in very broad terms, time, numbers of hours, and subject matter and that kind of thing are not spelled out in the acts but are subject

to the regulations of the various boards and committees and can be changed by national accrediting organizations. Those who have RT programs know that a live lab can reduce the number of clinical hours required.

If we work at it, this will keep changing. Another example is our Medical Practice Act, a very open act in comparison to many states that for years simply said,"Thirty-six months of education." Two years ago we even knocked out the thirty-six months to enable the deans of the medical schools to admit students with advanced standing. The deans have already done so in a couple of very interesting instances. Eventually, a long time from now, someone who has all of the education via experience, physician assistants, military men, etc., may be able to get advanced standing in the medical schools, without ever having been to a formal educational institution. Some of the deans, I know, are thinking in this direction. They do not have enough money to develop all the tests they need, but they have actually done some things. So the trend is good, but only in one act do we really spell this out.

There are other realities, such as qualifications of students and needs for preliminary education. However, in many cases, this is also subject to question, age, citizenship, and so on. Supposed qualificatory "realities" are being proved wrong all the time. Christine Allen, who runs the ADN program at Malcolm X Community College, claims that people criticize Malcolm X Community College because of the fact that only about fifty percent of the students who eventually graduate from the ADN program pass the state boards. Yet this is a fantastic accomplishment, because almost none of the students she takes in the first place meet test requirements which supposedly militate for success.

Therefore, if any of them get by, it defies all the odds and all the tests. The tests have got to be wrong. Malcolm X Community College is letting such students in. The college is not being conned into accepting only those who meet national standards, and they are getting students ready for their state board exams. It can be done if you have the guts.

We have done this with an upward mobility program at the University of Chicago hospitals and Olive Harvey College, where quite literally this spring we had a woman who started as a high school dropout aide climb the ladder to RN, getting credit all the way for what she knew at each rung. As an aide, she studied in a hospital sponsored high school equivalency program. She entered an LPN program with credit for what she knew as an aide and went into a part-time ADN program with credit for what she knew as an LPN. This can be done, but the program took a tremendous amount of fighting. It took, on the part of the former director of the state health planning agency, an actual appeal to the governor in order to bang the state board of vocational education over the head so that they would approve the program.

Within the realities framework, what do you do? First plan, and do what you want to do! We can look to our needed product. Never ask for permission to do something. Tell them this is what we want to do, and why, and let them try to stop us. We must not say we are "thinking about doing this or that." If it makes sense to our program and our people, we do it, and if anyone objects, we then open up the package and let everyone know we are going to open it up. If there is anything which has been a successful technique in dealing with silliness on credentialing and licensing boards over the eight years I have been in this state, it has been that old cry: "The whole world

is watching."

We must make certain the whole world knows in order to change things, since many of these things are not based on the law but are based on the interpretation people have given them. Under the power they will not stand up to scrutiny of law.

All must consider outside help. One real sadness of my life is the times when I have seen junior college A roll over and play dead, when at the other end of the state junior college B is doing exactly what A was told it could not do. Therefore, we must study, do our homework, and make certain that all our people are doing their homework, not taking somebody else's word for it.

There are some things we can do jointly in the next several years. We are in a climate that militates for curriculum flexibility, if for no other reason than for the fact that it is financially the thing we have to do. Our whole rationale in terms of health education manpower is involved with maldistribution and terrible misinterpretations of our real needs. We have no real health manpower policy for guidance. The status of the art of health manpower planning, most other kinds of manpower planning, is partly at fault. But things are happening. In health manpower planning I am currently on a federal committee which this summer is doing a 2,000 stop, personal-contact study of the status of the art of health manpower planning. What are planning agencies and consortia, education bodies, and other groups really doing? What are their mechanisms? I know that we are going to find that we need a great deal of continuing education in health manpower planning. We need people

educated in good planning methods in not just the planning agencies but in community colleges. Also, we are going to have to develop better methodologies and fund experiments, better ways of inquiring into real needs in manpower, and a better way to fit it all together. This is a part of the climate of changing curriculum, because if we improve our manpower planning methods, it is going to militate change. For education's response, we have such things as new university systems, the common market for higher education, the open university.

We have taken the first three steps to Lincoln State University which will grant degrees for many kinds of educational experience, regardless of where and how it occurred. If we are going to do this and the legislature is going to back this (and they already have), then the standards for what constitutes an approved school are going to have to change, and lawmakers are going to change if the guilds object too much.

We <u>are</u> living in a good climate. People can get a little scared about this. I hear junior college people worrying because there may be some faculty jobs go out the window if someone can prove he got the education some other way and does not have to put in 2,000 hours in class. But that is what we are supposed to be all about. We have a Social Security Amendments Section which says that by 1977 the secretary (of HEW) will have standards of equivalency for such things as LPNs, rad-techs, etc., and that they will not deny payment under title eighteen and nineteen of the Act. That is, the Medicare and Medicaid provisions state that just because a service is delivered by a qualified person who does not have a credential, payment must be made anyway. They will develop standards for equivalency. This makes a lot of difference

to community colleges. We may be working on getting people up to the standard for equivalency, and that might not have a thing to do with credentialing or licensing as we now know it.

We are running experiments with institutional credentialing right now in Illinois. In other words, we ask,"What does it take to do the job?" I think you recognize that many deliverers of health care, large hospitals and small particularly, act on their corporate responsibility and allow individuals who may not have credentials to perform certain kinds of health care. But by what process does the institution make this determination, and can we measure it in some way, perhaps even make this process part of the normal way of doing things? We have led in this in Illinois partly because of the landmark Darling vs. Charleston Hospital case, in which the state supreme court said that a hospital was responsible for the care performed there, regardless of the qualifications of the individual who performed it. The question naturally arose then: "If we are responsible, period, regardless of the fact that someone holds a license, then why can't we also do the reverse, determine whether or not someone is qualified?" This is institutional credentialing,and it has many implications for education.

All of these things, budget crunch, new federal legislation, health planning, the courts, educational change to a more open system, and more are militating for a far more flexible approach to curriculum. This, of course, is what community colleges in theory are supposed to be all about. We should be doing far more than support this kind of change; we should be part of it, and yet I s[illegible] community colleges becoming so institutionalized that they worry about [illegible]nge. Have we come so far toward "respectability" in a short

time that we have lost the sense of mission that drove the j.c. pioneers? I hope there is nobody here who thinks that way.

There should be only two kinds of limitations to curriculum flexibility. One is the need for the product. Is this the closest we can come to turning out a worker who is ready for today and tomorrow in his field? Or if he is not completely ready for tomorrow, will he at least be prepared to cope with the pain of change? Once many years ago, an old med school dean summed it up for me: "The problem of medical education is predicting the health care system of twenty years from now." That is the problem of all occupational education.

An effective product is one limitation we ought to have. The other is the safety of the public. Numerous crimes are committed in that name. We hide our ignorance and indulge too often in educational overkill because we do not want to wrestle with the problem of designing programs that meet the real needs of the field. Sometimes the motivation is a lot less pure than that, but the defense is always:"But we are dealing with human lives!" We ought to find out what is really necessary to safety. Why do we license about one hundred more occupations in Illinois than they do in Texas? Both states are the same size.

For all these reasons I have cited, not the least of which is the last, the health scepticism about former "givens" that I find pervading the health fields, I am looking forward to a much better world in curriculum flexibility in the next ten years, and I am gratified by the progress we have made in the last eight.

Just the other day I was sitting at a meeting of the Illinois Implementation Commission on Nursing, and the dean of a nursing school was giving a report for the education committee. She pointed out that the first thing we must consider, which is to be our ongoing thread, is mobility. When I took my job eight years ago, a sixteen-year-old girl had to make a decision as to whether or not she wanted to be a baccalaureate nurse--if she was not going to be penalized several years in the education process. Today, the first consideration of the nursing education committee is mobility. I turned to Dave Kinser of the Illinois Hospital Association and said, "It is time for me to leave; my work is done. I should now go and make trouble somewhere else."

In curriculum relativity and creativity, the community colleges have been the troublemakers in American education. The only way we are going to create and maintain curriculum flexibility for the good of students and the nation is to go on making trouble.

LIMITATIONS TO PROGRAM FLEXIBILITY: THE REALITIES OF PROGRAM OPERATION

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I want to refer quite closely to the accreditation process that is in existence for allied health programs. The scope of this particular message is practical in nature and realistic in its design. In addition, my approach intends to present program operation as it is applied to an actual program in any junior college, whether it is in southern Illinois or northern Kentucky or Ohio. My paper will cover four major areas: the dilemma of applying for accreditation; the difficulty of conforming to the essentials and the morass of paperwork prior to accreditation; the trauma of the site visit; and finally some immediate solutions which would make program operation as applicable to accreditation much simpler.

The Procedure of Applying

The definition of accreditation is that it is the process by which an agency evaluates or recognizes an institution or program of study as meeting certain predetermined criteria or standards. There are two kinds of accreditation in the United States. The regional accreditation that most of us are familiar with is North Central because that is the one to which we respond. The other type is specialized accreditation, and this is our basic concern now. That is, specialized accreditation, as it fits in with the allied health fields through many, many accrediting agencies, is rather essential to the allied health field because in order to sit for the licensure exam or be

eligible to take a registration or certification exam, one must have graduated from an approved school. Such schools, of course, are only approved after they have fulfilled the essentials or guidelines. One of the initial problems of the junior college concerning allied health is to decide the specific accrediting body that has the responsibility for a particular allied health program. In allied health, everything is not medicine.

For example, let us suppose I wish to start or that I need a physical therapy assistant program. To whom do I apply in order that I may get the appropriate accreditation so that my graduates will be able to sit for the registration or the licensure exam? This dilemma has many particular facets. The American Medical Association in collaboration or, rather, in a consortial effort with many specific health professions is responsible along with those specific health professions for such programs as the medical record technician program, medical laboratory technician program, radiologic technician program, etc. If by chance my school has a physical therapy assistant program, I go to the American Physical Therapy Association. If by chance I have a nursing program, I go to the National League of Nurses. If I am in the state of Illinois, of course, I have many different directions to go before I ever get to the NLN. If I have an operating room technician program, I apply to the American Operating Room Nurses, although I understand now that this accreditation comes under the AMA, which brings up special problems because I did indeed apply to the Operating Room Nurses Association. I went through the morass of filling out those forms only to find out that they had switched gears on us; so now there is a new agency and new forms.

A dental program would be accredited by the American Dental Association. From the new emerging health professions, such as the emergency medical technician, guidance toward accreditation and guidance towards programs is received by the American College of Orthopedic Surgeons. In general, whatever accreditation body has the responsibility for the program, I must submit on request a copy of the essentials and a "guideline" for setting up a program in a particular institution. At the same time in the procedure for applying, the institution will receive multitudinous forms which need to be filled out. These forms must reflect the abilities and talents of the staff and also the numerical quotations of examinations and talents of the clinical facility staff, whether the staff is assigned to the junior college or to the health delivery system.

Conformity To The Essentials

The essentials are the limiting factors to the curriculum of each and every allied health program in the junior college. The author of the essentials is basically one individual in the joint review committee or licensure board, as is the case with licensing specifically in the state of Illinois. In most cases, this individual tends to be a professional, primarily a clinician. Two points should be illustrated here as affecting the junior college allied health educator: 1) there is no input at this time from any allied health educator or any educator generalist; 2) essentials written primarily by clinicians tend to be clinically oriented. More specifically, the essentials evidence a sick-people-oriented curriculum.

Many of the essentials and their specific applications tend to be oriented to the student who takes care of the hospital patient rather than to the student who wants to broaden his knowledge of areas such as preventive medicine, environmental medicine, or even geriatric medicine. In regards to curriculum flexibility, this is a limiting factor.

In addition to the essentials, there is more specific information called guidelines. Such things as the interpretations of the Nurse Practice Act are probably best called guidelines. These materials are intended to be just that, guidelines to junior colleges. One of the immediate curriculum flexibility problems that comes from these guidelines is that they tend to be a subject of gossip to site visitors, thus causing bad remarks to be returned in the report by the site visitation team. Therefore, the breakdown within the essentials must be reviewed in order to denote some of the specific problems that junior colleges have in complying with the essentials.

The first category within the essentials is administration and organization. Many specific health occupations request that a medical director be assigned for the program. This medical director in many cases is primarily an X-ray pathologist or radiologist. The historical connotation of naming a medical director, in my estimation, is to put in some superior direction, such as the age-old hospital diploma programs. As everybody knows, physicians have just a little bit more education and God-like qualities than the rest of us. Thus, the junior college administrator does not find fault with appointing a medical director except that his expertise in educational matters tends

to be rather severely limited. All agree to that finally. Failure of the junior college to follow the director precipitates his resignation as the medical director, and this, consequently, causes the junior college to go out and find another medical director who is approved by the specific health profession.

The next point under administration and organization is the defining of the affiliate and the sponsor. Generally, it is noted by junior colleges that if they grant the degree in a specific health profession, they should very obviously be the sponsor. The hospital-based clinical facility should be the affiliate. This has and will be contested by many hospital-based programs which are traditional and refuse to let educational institutions educate. The essentials fail to accent and define the affiliate and the sponsor. However, there have been some changes made to define the affiliate and sponsor, especially in the radiologic technology guidelines which have not yet been approved.

The third point under administration and organization is that an advisory committee is defined to the extent of suggesting specific members. The junior college member accepts advisory committees because they are essential to <u>all</u> occupational programs. It is only right, though, that the junior college reserve the right to appoint the specific people to the advisory committees. Also, it should be noted that physicians tend to be honored by the appointment but fail oftentimes to show up for the advisory committee meetings.

The second category under the essentials is services and facilities. My points are basically these: the essentials pinpoint the fact that certain

square footage is necessary for either simulated clinical facilities or clinical facilities within a hospital institution. My contention is that square footage is not relevant to the educational process of the student.

My second point is that the number of clinical examinations that are required are based on the assumption that the number of examinations is an indication that the student is getting full and complete clinical affiliations. The essentials direct the junior college to use only clinical facilities that have either a sufficient number of examinations or multiple clinical facilities which total the amount of specific examinations. Junior colleges contend, very obviously, that again the number of examinations are not important but that the types of examinations definitely are. An institution that primarily does chest radiographs could fulfill the requirement of 1,500 radiologic technologic program. However, the student would not have any experience in special procedures such as gall bladders, or GI's, etc.

The third area of the essentials is the faculty. Within this area is the physician who is an instructor. Some specific subjects are allocated to physicians. Historically, physicians have been known to be primarily clinicians. Their ability as instructors, especially as instructors of anatomy and physiology, is rather limited. Years of experience for particular faculty members are required by the essentials. Arbitrarily assigning three years of experience to a faculty member in order to take for granted that those three years will make him a tremendous teacher is certainly not born out by research. The junior college administrator contends that a combination of clinical

experience and educational experience is necessary for a talented instructor.

There is also the necessity of degrees. The requirement of a master's degree for a specific health profession limits the flexibility of the junior college. Junior colleges contend that the talent of the instructor should be taken into consideration and not specifically his need for such and such a degree. This, incidentally, does not refer to the AMA essentials; it refers to the physical therapy assistant essentials, which I understand may be changed. The number of faculty, arbitrarily again, indicate that the student-teacher ratio should range anywhere from one to one or from one to three. Educational research and experience have shown that the talents of the instructor and a well-planned clinical curriculum are more essential than a specifically defined student-faculty ratio.

Educational programs express the number of hours which ought to be spent in a clinical facility. The radiology technology essentials indicate that the student must spend 2,400 contact hours with the patient. In all fairness, I must say that the essentials indicated that if there were a simulated lab, the student could knock off 200 hours. That leaves 2,200 hours of clinical contact with a patient. A simulated lab costs approximately $45,000. A phantom, which is what the students use to play with and take X-rays of, costs another $5,000. So for $50,000 a student can get 200 hours knocked off his specific clinical requirements. This is a joke.

Junior colleges contend that behavioral objectives that are assigned to the student in a clinical facility provide the student with more experience

than a simple, dogmatic number of hours. The essentials designate specific academic transfer courses requiring that students take courses such as math and chemistry. Guidance counselors of junior college systems have the ability to recognize in high school transcripts the strengths and weaknesses of a student in specific courses. The student in many advanced high school curricula may have had a sufficient amount of math and chemistry and, thus, does not necessarily need to take those subjects in a specific health profession program in the junior college. When the essentials indicate specific courses to be taken by the student, a junior college with a series of allied health programs tends to have many courses within the allied health department that are similar to other offerings but different enough to satisfy the essentials. This fragmentation costs many dollars and prohibits core courses from coming about.

For example (and this is the example everyone uses when he gripes about essentials or particular rules), medical law and ethics is very much a part of each allied health curriculum and is required by the essentials. An essentials course entitled ethics is applicable to all allied health professions and prohibits this specific fragmentation. There are many other examples. There are instances even in our own programs where the nursing faculty takes the physical therapist out of the local hospital in order that we may teach two hours of physical therapy to nursing students; whereas, in our own department we have a physical therapy assistant program with a physical therapist who could very obviously relate to that nursing instructor and nursing objectives and nursing students.

Filling Out Forms

Forms are required for any particular accreditation. The forms required to be filled out after the junior colleges have attempted on their own to fulfill the essentials have similarities between each allied health profession, but it is necessary for each particular profession to be reviewed in order to reacquiesce to its specific set of forms. That is, there are many many sets of forms. After the forms are submitted, there is the possibility that the staff officer in each particular creditation office will correspond and suggest that curriculum changes be made. There have been some independent studies on the amount of time and money needed to fill out the paper work required by the forms. It is not unreasonable to suggest that the junior college spend $200 for each set of forms. If curriculum changes are suggested by staff officials upon receipt of the forms, it is possible that it costs $50 for each simple curriculum change just in dealing with the in-house work. We are not really talking about going to the Illinois Junior College Board. There is very often a time lapse of possibly eighteen months to two years between the paper work and the visitation of the professionals assigned to an institution for the site visit. Within that time, curriculum changes do take place and are initiated by both the faculty and the advisory committee. Needless to say, these curriculum changes must not only be explained to the staff officials of the health profession but, more specifically, explained to the site visitors, for site visitors are operating on the paper work submitted eighteen months previously.

Site Visits

Site visitors and their visitation present multiple problems to the junior college particularly because there is a site visit for each of the allied health programs. It is not uncommon to cost out a site visit at $600 for two days. This cost only includes the college staff and faculty applicable to that site visit team. Such things as their professional time, car mileage, dinners, meetings with the presidents, deans, and hospital staff meetings are all required within the site visit. It is necessary to remember that this $600 figure is applied to each site visit. Most health profession societies will send a physician and a technician. Of late, the technician tends to have some educational background, but the visitors tend to be rather ill-prepared for their task. Their preparation as to the type of questions that should be asked has been rather limited. On the other hand, some visitors seem to have been indoctrinated as to the qualities of their own institution. With many of us operating on the premise that all institutions are not alike, it might appear that our approval of a specific health occupation might depend on our correlating that specific curriculum with the curriculum of the site visitor. The site visitors, upon termination of their visit, are required to fill out a report. Some reports are open-ended while others tend to be the visitors' answers to specific questions. Generally, most institutions receive what one might call a subjective, independent judgment by the site visitors. Thus, the site visitors have failed to use any objective means of evaluating an institution.

The report is then sent to the review body that in turn either approves or rejects the report, thus indicating whether the school is accredited and

whether the students are allowed to sit for the licensure and registration exams. If the report is approved by the site visitors, it goes on to the appropriate bodies for their approval.

The next body within the AMA is the joint review committee and so on through its structure. In this state nursing goes on to the Board of Nurse Examiners. With this process there are maybe suggested curriculum changes which, of course, cause expenses within an institution and corresponding difficulty of changing curriculum with the junior college board and other appropriate state agencies.

Incidental to all this, providing the institution has received approval, such things as future paper work indicating curriculum changes, faculty changes, and yearly reports are quite necessary and must be submitted. Most of us who have had very active advisory committees and who are on top of the clinical aspects of our allied health programs suggest curriculum changes repeatedly. These curriculum changes must be passed on to the appropriate accrediting agency. The agency, in turn, along with the junior college board and the curriculum instruction committee, must approve each of these changes. The rise of frustration and time usage caused by each of these changes tend to make the allied health administrator minimize any desire by either the faculty or the advisory committee to suggest curriculum changes.

It has been noted among some junior colleges that the site visitors have indicated approval of programs. Yet the joint review committee, which is the next step in the approval process, has not allowed the program to be accepted

because of a violation of some basic rules. One noted example, the Monroe Community College in New York, has been a victim of these circumstances. Supposedly their students did not fulfill the 2,400 contact hours requirement of the joint review committee of radiologist technologists. The site visit team reviewing the program saw that the 2,400 hours did not make any difference and consequently reported their acceptance of this new concept. The question of whether the students would be allowed to sit for the registration exam became apparent. In the dilemma and confusion of the time, the students were allowed to sit for the exam and they all passed, but in the meantime the joint review committee refused the acceptance of the site visit team report and, therefore, denied the approval of the program. As a result, the students who had already taken the exam but had not received their scores were told they would not be registered even though they had passed the exam.

There are, however, some immediate solutions that may help: 1) the appointment of an educational generalist to the joint review committees (the joint committee is the body which makes the essentials, and it does not have any specific educational input except from technical educators); 2) the consolidation of the review process to include all health programs so that there are no multiple visitors; 3) the financing of the accreditation process by the educational institutions; 4) the addition of an educational generalist to the review teams and to the site visitors; 5) a formal preparation of an evaluation by site visitors; 6) control of the growth of newly emerging professions, as applied to accreditation (for example, the emergency medical technician profession and all new professions result from grants from Robert Wood Johnson to straighten out the allied health programs); and 7) all medical professions or those professions having to do with health care delivery

should be accredited by one body.

These seven solutions can be very easily put into effect with a great deal of work on the part of everyone.

A PRESCRIPTION FOR LIVING WITH LIMITATIONS: THE VALUES OF COOPERATIVE RESOURCE SHARING

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There are some golden opportunities that one can build on from such a conference as this one on career education. The first of the golden opportunities is right here in Illinois. There is a legal, official obligation to move forward in state-wide planning and to come up with a tangible, demonstrable product that flows from the planning process. This is an outgrowth of a legislative requirement, a follow-up by the Illinois Board of Higher Education, and a directive from that board to the Illinois Junior College Board. Dr. Richard Brown, who used to be the executive director of the Illinois Board of Higher Education, and I are serving as consultants to help the Illinois Junior College Board develop this latest state-wide plan for community college education.

This work is moving forward very well. It has accomplished already one checkpoint--a plan for each of the operating colleges in each of the community college districts. This phase is now a basis for program projections, interrelationships between program projections, and related questions which will help the Board identify either gaps in services to the people in Illinois through community college educational programs and services in over-lappings and duplications in these. All this is very relevant to the fact that Southern Illinois University at Carbondale is working with a number of community colleges within the southern section or region of the state in ways that look into the future and essentially ask the same kinds of questions

that are being asked as the state-wide community college plan is being projected.

The second opportunity that is before us is less visible at this moment. It is more of a potential than an immediate possiblity. And yet it is one of the threads in the total fabric that has to be known, recognized, and looked at as tying the planning process together. I am referring to the comprehensive state-wide planning for post-secondary education that requires every state, if it is going to obtain money from the federal government in a number of programs, to establish what is called a "1202 Commission." Section 1202 of this law requires that each state establish a commission for comprehensive planning and then file that plan with the federal office in order to get certain federal aid.

The law (P.L. 92-318) was passed last summer but when motion was started to get comprehensive planning ventures in place and to set guidelines, the 1202 Commission's difficulties emerged. After development of a combination of circumstances, there came a stopping point in March, 1973.

The combination of circumstances included a division of support of the propositions from within the higher education community itself. Prestigious universities, both public and private, began to see that there were some threats in the establishment of comprehensive state-wide planning arrangements in each of the states. These universities feared for their autonomy; they feared for their freedom of operation; and they began to raise some serious questions as to whether this was a good thing. Also, it should be noted, the community colleges were a bit suspicious of the possibility that the planning

function might become so captured by the universities that they (the community colleges) would not be fairly recognized in any significant way in the plans that might emerge.

The widespread expression of doubt within the academic community itself slowed down the development of regulations. The clincher to stopping the planning impetus, however, came when President Nixon decided that he was going to withhold funds. As a result, work on federal guidelines on the 1202 Commission ceased when the acting United States commissioner of education sent out a stop-action letter to the field. I tell this story because I think it is a bit of new information that might encourage people to do more of what has been going on yesterday and today at this conference.

At a meeting recently in Washington, following up on a series of congressional hearings on P.L. 92-318 and its required 1202 Commission, Congressman O'Hara, Chairman of the House Subcommittee on Education, made a statement advising the state representatives to proceed. He advised the state higher education executive officers that there was no need to accept the administrative decision that has been promulgated in Washington over the acting United States commissioner's letter. Congressman O'Hara's report went something like this: The Higher Education Amendments are law; they were passed by Congress and signed by the President last summer, 1972; the law is operative now and calls for each state to establish a mechanism for comprehensive state-wide planning; and according to this law when such a commission is established in a state, action is taken and reported to the United States commissioner of education, federal funds must follow. The law does not say, he said, that the release of the money is permissive.

Congressman O'Hara then told the state representatives that his recommendation would be that they go ahead and organize the commissions, file the fact that they had done as the law required with respect to local and state action and to reporting to the United States commissioner of education, and request the planning money. I understand now that a number of states are moving along those lines. It will be interesting to see what happens when those states ask the United States commissioner of education to release the planning money which is available.

All this also ties in with what is going on in southern Illinois. It is all part of this exchanging of information concerning institutional purposes, institutional programs, and ways and means whereby institutions of post-high school level not only can but must get together to match goals, compare resources, and examine their relative roles and educational missions in order that collectively there can be a more efficient, a more effective, and a more comprehensive response to the needs of the people in post-high school education.

But relatively few promising activities are occurring that speak to the question: Can colleges and universities, community colleges, area vocational schools, technical institutes, public or private, so long as they are in the area, get together and do this kind of thing? Frankly, there are not many places where one can point with pride and say, "Yes, here is an illustration of what is going on; this is either productive or potentially productive and an example which others may copy."

In the field of allied health services, there is such an example in the program that has been regionally developed in western New York around the

School of Allied Health of the State University of New York at Buffalo and cooperatively with a network of public community colleges and one state supported two-year college. Included are Alfred Agricultural and Technical College, Erie, Monroe, public community colleges, and the School of Allied Health of the State University at Buffalo. Capitalizing on the requirements and some support from the federally supported programs and the regional health planning conference and health planning, these schools have moved forward very well in working out a comprehensive program. It covers not only the technical level and baccalaureate level allied health fields but also some of the trade levels, such as licensed practical nursing. Relatively few community college health careers programs have such a tie to the baccalaureate level, the professional level encompassed in the career ladder.

In implementing this program the university has clearly defined a set of functions that it is committed to perform. The community colleges and the regional state supported two-year college have done so, too. All are sharing clinical resources and professional instructional resources. More importantly, students are being grouped together and moved together to different learning places to capitalize on the programming and the resources in that western New York area.

We should be quick to grant that this is still a trial. They do not have all the answers, and they are running into some real problems. However, I believe they are on the right track and I offer the suggestion that you look at it carefully. Although admittedly I do not understand sharply the geography, or the institutional layout in southern Illinois, or the relative strengths and weaknesses that the cooperating institutions bring to the consortium idea

here, you may get some help from the western New York plan. There is enough of a parallel evident that possibilities of profit by looking at what they did should not be overlooked.

Southern Illinois institutions quite clearly must begin now to examine some of the nitty-gritty of operational arrangements that are inherent in a consortium approach; they need to work out a scheme for an educational division of labor and joint use of materials between Southern Illinois University at Carbondale and its programs and commitment and resources and a network of community colleges with their resources. It makes abundant sense. Southern Illinois University at Carbondale, it should be emphasized, has an unusually fine personal resource to do this kind of thing. Dean Arden Pratt knows the community college; he has been in it; he is sympathetic to it; he understands its strengths and its weaknesses; and he has a tie-in with the university arrangement. There is an advantage in having someone like that who has that background and competency to work with the university staff in developing arrangements where they may be helped. I think everybody in this kind of consortium has an opportunity to profit and as the result, the payoff is a better educational service.

Basic to the entire concept of a consortium or a regional plan is a positive institutional attitude or posture. Here again I have to draw on my New York experience because the leadership there has been attempting to develop a regionalized approach to post-secondary education throughout the state for several years. In order to do this effectively, the necessity of positive attitudes toward cooperation must be understood from the very start. The first principle is that all of the educational interests involved

must either have some resources to contribute or some program commitment to which the thrust of subject matter of the consortium can relate. That is to say that one must look and see if anything is being left out.

There are no private institutions in this section of Illinois, but what about at the high school level? High schools have programs which are occupational and to some degree move toward the technical level. In some instances, high schools are grouped into area relationships, and I think, therefore, that any consortium that deals with a specific in the occupational area, whether it be allied health or business or anything else, needs to consider the high school level, too. The principle is still there; and we ought to start looking at the program's articulation effectiveness, both downward to the high school as well as upward to the baccalaureate level. At least in the communication sense, if not in an operational participatory sense, the question of the high school ought not be overlooked.

Next, as already indicated, one ought to look toward the baccalaureate level because it is not going to be sufficient to develop a community college program that looks at any area of the occupations and does a complete job there. If it meets the manpower requirements at that level, it helps people fulfill their ambitions and their aspirations through the technical level and then stops; it is incomplete. There has to be an upward mobility possible for those students who complete the occupational programs and wish either immediately or later to acquire some kind of further occupational training opportunities.

This is where a university such as Southern Illinois University at Carbondale has not only an opportunity but an obligation. It is up to the

university to provide baccalaureate level programs in the occupational field. I understand there is a technical careers program here at Southern and that is a step forward. It is good because that gives Southern Illinois University at Carbondale a programmed capacity to bring into the consortium a capacity for full comprehensiveness in the planning and implementation of needed programs and services, both in the vertical sense and in the horizontal sense of curriculum development.

Please understand I am not advocating that community college occupational programs should be converted to lower-division, pre-professional programs leading to baccalaureate professional degrees. I am advocating a planned articulation of discrete occupational preparation occurring at two educational levels--community college/ technical, and university/ professional. They are related but different, and this should be kept constantly in mind.

The final principle is that in the development of a consortium none of the participants has the freedom to discuss or enter into the consortium on his own terms. This is difficult to say and difficult for some people to hear. But the minute an institution enters into a consortium, a cooperative venture, it has got to give as well as to get something. If anyone insists on going into it on his own terms, then the consortium is doomed to failure. This means that the community college participating in a consortium must think in terms of yielding a bit of its autonomy and freedom to that consortium. Authority must be delegated or supervised, but still the consortium must be free to do what it is designed to do. Consequently, and necessarily, there is some delegation of autonomy. Likewise, the university, if it is going to be a viable participant in a consortium of community colleges, cannot

have all the decisions on its own terms. It is in the very nature of a cooperative venture that the mechanism that results contributes to the wishes and to the advantages of all the participants. This also requires some yielding authority from all of the component parts. However difficult and troublesome the implementation of such concepts in higher education may be, I do believe this to be the wave of the future.

I am now involved with the American Association of Junior Colleges on another project, a task force that is looking at ways and means for colleges to join forces in consortia and other regional arrangements. It is clear that small and large colleges, either public or private and alone, do not have enough resources to do the whole job they face alone. That fact, coupled with the fact that resources are hard to come by, all speak to the same conclusion. We must work together if we are going to get the full post-secondary educational job done and gain at the same time the respect of our supporting agencies whether that support be a public legislature or private constituency.

SELECTED COMMENTARY

"Please attain and maintain throughout the report the spirit of heresy which was presented throughout the meeting."

"This was one of the most interesting and informative conferences that I have attended for some time. I suspect that I am reacting in this way due primarily to the high quality of the speakers."

"I enjoyed every minute spent with the group."

"I enjoyed very much each of the speakers whom I heard, and felt that what they presented was meaningful and authoritative."

"I believe that there was a distinct advantage to limiting the number of participants to an easily handled group."

"I would personally have preferred to see the conference start at an earlier point in the day than the evening. I like an evening session to follow some activities which could start at noon."

"I strongly support a well-timed conference with meetings beginning and ending as published. This at least creates an impression of a well-oiled conference machinery and does much to create a better climate. I found this to be true of this particular conference."

"If the conference had any shortcoming, it would seem that few coping devices were identified for a litany of existing problems. Otherwise, I found the workshop to be informative."

"The conference was extremely informative as to current thinking concerning allied health consortia and career ladder concepts. The views presented by Ralph Kuhli and Don Frey were refreshing. It appears a considerable awakening is taking place in education."

"Overall, the conference was well organized and planned. This I like, and I am certain the other participants did also. I would like to see a continuation of meetings of this type."

"I feel the meeting relative to the health area was beneficial. This initial benefit will, no doubt, be more of an 'ice breaker' in getting people together and discovering they have similar problems or tasks."

"I came down to dissent but you did it so much better than I could that I had nothing with which to disagree. It was a good meeting. I am glad I came."

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COUNCIL ON
MEDICAL EDUCATION

March 1973

ALLIED MEDICAL EDUCATION FACT SHEET

ORGANIZATIONS, The Council on Medical Education, American Medical Association collaborates with:

1. American Academy of Family Physicians
2. American Academy of Orthopaedic Surgeons
3. American Academy of Pediatrics
4. American Association for Inhalation Therapy
5. American Association of Blood Banks
6. American Association of Medical Assistants
7. American College of Chest Physicians
8. American College of Physicians
9. American College of Radiology
10. American College of Surgeons
11. American Hospital Association
12. American Medical Record Association
13. American Occupational Therapy Association
14. American Physical Therapy Association
15. American Society of Anesthesiologists
16. American Society of Clinical Pathologists
17. American Society of Internal Medicine
18. American Society for Medical Technology
19. American Society of Radiologic Technologists
20. American Urological Association
21. Association of Operating Room Nurses
22. Association of Operating Room Technicians
23. Society of Nuclear Medical Technologists
24. Society of Nuclear Medicine

Accreditation of allied medical educational programs is a collaborative process: *Essentials* are developed and endorsed by the allied health and/or medical specialty societies concerned with a particular occupation and submitted to the Council on Medical Education for adoption by the AMA House of Delegates. Educational programs are approved by the Council on Medical Education on the recommendation of review committees appointed by the collaborating organizations. The Council's Advisory Committee on Education for the Allied Health Professions and Services advises the Council on matters concerning allied medical education; a Panel of Consultants consisting of representatives of the collaborating organizations provides consultation to the Advisory Committee and Council on Medical Education in matters concerning allied medical education.

AMA Approved Educational Programs in Allied Health Occupations

Allied Health Occupation	No. of Programs 3-1-73	Student Capacity 7-1-72	1971 Student Data Enrollment	Graduates
1. Assistant to the Primary Care Physician	46	490	+	+
2. Certified Laboratory Assistant	192	2,487	2,753	1,969
3. Cytotechnologist	111	631	349	340
4. Histologic Technician	15	37	35	21
5. Medical Assistant	45	1,125	1,228	414
6. Medical Assistant in Pediatrics	*	+	+	+
7. Medical Laboratory Technician	2	+	+	+
8. Medical Record Administrator	30	612	306	254
9. Medical Record Technician	39	1,028	1,119	269
10. Medical Technologist	754	8,685	6,434	5,367
11. Nuclear Medicine Technician 12. Nuclear Medicine Technologist	35	290	203	99
13. Occupational Therapist	39	1,904	1,472	769
14. Operating Room Technician	*	+	+	+
15. Orthopaedic Physician's Assistant	8	86	100	28
16. Physical Therapist	59	2,102	2,097	1,547
17. Radiation Therapy Technologist	37	150	123	63
18. Radiologic Technologist	1,102	19,021	17,816	6,661
19. Respiratory Therapist	126	2,280	3,001	749
20. Respiratory Therapy Technician	*	+	+	+
21. Specialist in Blood Bank Technology	53	+	+	+
22. Urologic Physician's Assistant	*	+	+	+
TOTAL	2,703	40,928	37,036	18,550

* Essentials adopted; programs under evaluation; approval pending. + Not available.

ALLIED MEDICAL EDUCATIONAL PROGRAMS

Occupation	EDUCATIONAL PREPARATION		
	Enrollment Pre-Requistes	Minimum Program Length	Credentials
1. Assistant to the Primary Care Physician	as required by individual programs	varies 1 year to 4 years generally	under development by AMA + National Board of Medical Examiners
2. Certified Laboratory Assistant	high school or equivalent	12 months	Certified Laboratory Assistant CLA(ASCP)
3. Cytotechnologist	(1) 2 years college, (2) registered MT(ASCP), or (3) baccalaureate degree	12 months	Cytotechnologist CT(ASCP)
4. Histologic Technician	high school or equivalent	12 months	Histologic Technician HT(ASCP)
5. Medical Assistant	high school or equivalent	1 or 2 academic years	Certified Medical Assistant CMA
6. Medical Assistant in Pediatrics	high school or equivalent	2 academic years or equivalent	Certified Medical Assistant in Pediatrics (CMA)
7. Medical Laboratory Technician	as required by sponsoring educational institution	2 academic years	Medical Laboratory Technician MLT(ASCP)
8. Medical Record Administrator	(1) high school or equivalent, or (2) baccalaureate degree	(1) 4 academic years or (2) 1 year graduate level	Registered Record Administrator RRA
9. Medical Record Technician	high school or equivalent and typing proficiency	minimum is 9 months most are 9 to 24 months	Accredited Record Technician ART
10. Medical Technologist	90 semester hours college credit (3 years)	12 months	Medical Technologist MT(ASCP)
11. Nuclear Medicine Technologist	(1) medical technologist, (2) radiologic technologist, (3) registered nurse or (4) 90 semester hours college	12 months	MT(ASCP) or RT(ARRT)
12. Nuclear Medicine Technician	high school graduation and college admission test	12 months	MT(ASCP) NMT or RT (ARRT)
13. Occupational Therapist	varies and is dependent on admission requirements of the college	(1) 4 academic years, or (2) up to 2 years post-baccalaureate	Registered Occupational Therapist OTR
14. Operating Room Technician	as required by sponsoring educational institution	1 year	Certified Operating Room Technician CORT (AORT)
15. Orthopaedic Physician's Assistant	high school or equivalent	2 years	
16. Physical Therapist	varies and is dependent on admission requirements of the college	(1) 4 academic years, or (2) up to 2 years post baccalaureate	state license required
17. Radiation Therapy Technologist	(1) radiologic technologist, (2) registered nurse with course in radiation physics or (3) equivalent training	12 months	Registered Technologist RT(ARRT)
17a. Radiation Therapy Technologist	high school or equivalent	24 months	Registered Technologist RT(ARRT)
18. Radiologic Technologist	(1) high school or equivalent college entrance test	24 months	Registered Technologist RT(ARRT)
19. Respiratory Therapist	high school graduation or equivalent	2 years	Registered (ARIT)
20. Respiratory Therapy Technician	high school graduation or equivalent	1 year	Certified Inhalation Therapy Technician (ARIT)
21. Specialist in Blood Bank Technology	(1) M.T.(ASCP) or (2) baccalaureate degree, science major, and 1 year clinical laboratory	12 months	Specialist in Blood Bank Technology (ASCP) BB MT
22. Urologic Physician's Assistant	high school diploma or equivalent; some experience preferred	2 years	Certified Urologic Physician's Assistant

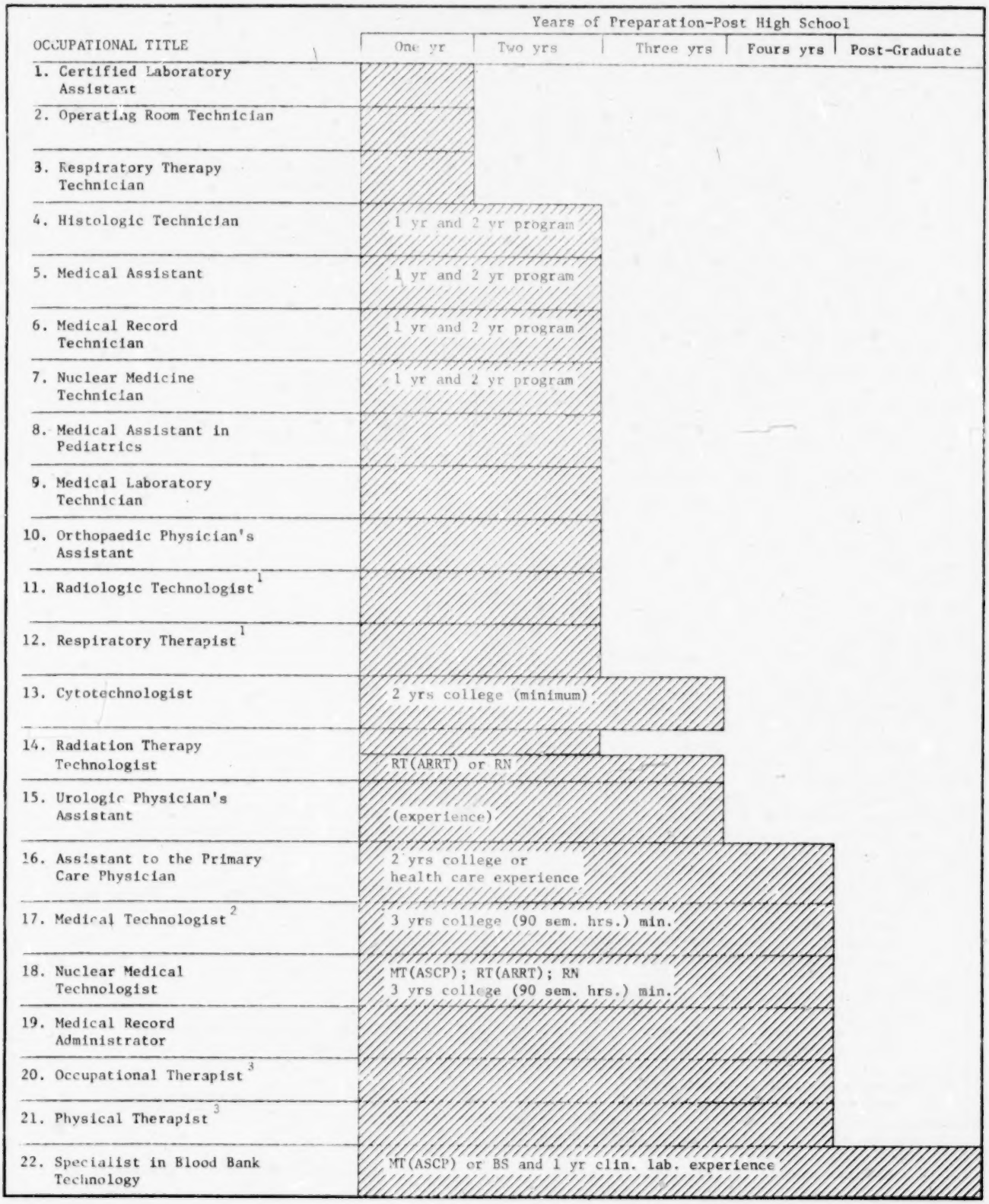
TRENDS, Trend data indicates a general increase in class size and overall enrollment. There is a significant trend toward junior college and vocational school sponsorship of allied medical educational programs. More than 150 AMA-approved allied medical programs are based in junior colleges or vocational schools. Educators are experimenting with innovative educational concepts and rejecting the traditional emphasis on length of program and required courses. New programs are being designed to produce competency levels, placing less emphasis on didactic instruction. *Essentials* are being revised to allow more innovative training programs to be considered for AMA approval, and educators are seeking to accomodate students with non-traditional backgrounds through equivalency testing and proficiency examinations.

REVIEW COMMITTEES

The Collaborating Organizations draft and approve *Essentials* and Revision; and their review Committees review education programs applying for accreditation

1. Accreditation Committee American Occupational Therapy Association	Occupational Therapist
2. Board of Schools (ASCP) American Society Clinical Pathologists American Society for Medical Technology and the committees on: Certified Laboratory Assistant Cytotechnologist Histologic Technician Medical Laboratory Technician American Association of Blood Banks Committee on Education	 Certified Laboratory Assistant Cytotechnologist Histologic Technician Medical Laboratory Technician Medical Technologist Specialist in Blood Bank Technology
3. Committee on Accreditation in Basic Education American Physical Therapy Association	Physical Therapist
4. Curriculum Review Board American Association of Medical Assistants	Medical Assistant
5. Education and Registration Committee American Medical Record Association	Medical Record Administrator Medical Record Technician
6. Joint Review Committee on Educational Programs for the Assistant to the Primary Care Physician American Academy of Family Physicians American College of Pediatrics American College of Physicians American Society of Internal Medicine	Assistant to the Primary Care Physician
7. Joint Review Committee for Inhalation Therapy Education American Association for Respiratory Therapy American College of Chest Physicians American Society of Anesthesiologists	 Respiratory Therapist Respiratory Therapy Technician
8. Joint Review Committee on Educational Programs for the Medical Assistant in Pediatrics American Academy of Pediatrics American Assocation of Medical Assistants	Medical Assistant in Pediatrics
9. Joint Review Committee on Educational Programs in Nuclear Medicine Technology American College of Radiology American Society of Clinical Pathologists	 Nuclear Medicine Technologist Nuclear Medicine Technician
10. Joint Review Committee on Education for the Operating Room Technician American College of Surgeons American Hospital Association Association of Operating Room Nurses Association of Operating Room Technicians	Operating Room Technician
11. Joint Review Committee on Education in Radiologic Technology American College of Radiology American Society of Radiologic Technologists	 Radiation Therapy Technologist Radiologic Technologist
12. Program Evaluation & Review Board American Urological Association	Urologic Physician's Assistant
13. Subcommittee on the Training of the Orthopaedic Physician's Assistant American Academy of Orthopedic Surgeons	Orthopaedic Physician's Assistant

Length of Educational Programs for Allied Medical Occupations


Years of Preparation-Post High School
One yr
Two yrs
Three yrs
Fours yrs
Post-Graduate
OCCUPATIONAL TITLE
1. Certified Laboratory Assistant
2. Operating Room Technician
3. Respiratory Therapy Technician
4. Histologic Technician
1 yr and 2 yr program
5. Medical Assistant
1 yr and 2 yr program
6. Medical Record Technician
1 yr and 2 yr program
7. Nuclear Medicine Technician
1 yr and 2 yr program
8. Medical Assistant in Pediatrics
9. Medical Laboratory Technician
10. Orthopaedic Physician's Assistant
11. Radiologic Technologist[1]
12. Respiratory Therapist[1]
13. Cytotechnologist
2 yrs college (minimum)
14. Radiation Therapy Technologist
RT(ARRT) or RN
15. Urologic Physician's Assistant
(experience)
16. Assistant to the Primary Care Physician
2 yrs college or health care experience
17. Medical Technologist[2]
3 yrs college (90 sem. hrs.) min.
18. Nuclear Medical Technologist
MT(ASCP); RT(ARRT); RN
3 yrs college (90 sem. hrs.) min.
19. Medical Record Administrator
20. Occupational Therapist[3]
21. Physical Therapist[3]
22. Specialist in Blood Bank Technology
MT(ASCP) or BS and 1 yr clin. lab. experience

[1]Some programs offer baccalaureate degree

[2]Some programs require BS: 4 yrs college plus 1 yr graduate work

[3]Some programs offer 2 yrs graduate (master's) degree

Subcommittees of the Advisory Committee

1. Subcommittee on Continuing Education

H. Robert Cathcart, Chairman
Betty Byers, MT(ASCP)NM
Larry Gessner, CORT
J. Rhodes Haverty, M.D.
Rosser L. Mainwaring, M.D.
Warren G. Ball, D.D.S., Secretary

Because of the need for assuring continued competency, and in view of the rapid pace of technological developments within the allied health professions and services, the need and demand for effective, well-organized programs of continuing education for allied health professionals has become increasingly apparent. Although all professional organizations provide opportunities for continuing education of their membership, it is felt that greater emphasis should be placed on an inter-disciplinary approach based on the components of the health care team.

The Subcommittee has defined continuing education as a formalized learning experience designed to expand the knowledge and skills of allied health professionals who have completed preparatory education. As distinguished from advanced education, continuing education courses tend to be more specifice in nature, and of generally shorter duration. The Subcommittee also determined that in-service education is regarded as a program administered by the employer, designed to upgrade the knowledge and skills of employees, essentially related to specific job assignments. The Subcommittee has identified the following sources of continuing education for allied health professionals: professional organizations (medical specialty and allied health), school of allied health professions, medical schools, voluntary health agencies, regional medical programs, hospitals and commerical firms.

In order to determine the current status of continuing education for the allied health professions, a number of surveys are to be conducted. Amoung these will be surveys of professional organizations and educational institutions, as well as agencies involved in certification and registration. The Subcommittee will also explore the development of appropriate incentive mechanisms similar to the AMA Physician's Recognition Award. Regarding the financial aspects of continuing education, the Subcommittee supports the concept that the continuing education of allied health professionals should be identified with the legitimate costs of patient care.

Consideration will be given to the feasibility of development of a comprehensive periodic listing of programs offered by professional organizations and educational institutions. However, preliminary discussion has revealed that this function may be more useful and effective as a service of individual professional journals.

2. Subcommittee on Common Courses and Career Mobility

James P. Steele, M.D., Chairman
Richard A. Ament, M.D.
Sister Anne Joachim Moore
Martha Phillips, VA
Daniel R. Thomas, AHA
John J. Fauser, Ph.D., Secretary

One of the resolutions from the October 1970 AMA Congress on Health Manpower that was referred to the Council on Medical Education through the Board of Trustees was that health career training programs should be based on a "core" experience with frequent opportunity for a choice of specialty area. The organization of technical training should be by clusters of occupations to prepare duo-specialists or even tri-specialists, in order to avoid overly narrow and restricted training.

In June, 1971, the Council on Medical Education agreed that "The Advisory Committee on Education for the Allied Health Professions and Services of the Council on Medical Education, through its Subcommittee on Core Courses and Career Mobility, would address itself to this need."

To the present time, the Subcommittee has attempted to serve as a facilitator in the ongoing dialogue and as a clearing house for information in these areas. A selected bibliography of studies, articles, and existing efforts to implement the concepts of core curriculum and career mobility is available for distribution.

A "glossary of terms" related to these areas has been developed and will become a part of a "how-to-do-it" handbook that is in preparation.

One of the major objectives of the Subcommittee is to explore the feasibility of establishing a counselling service within AMA to assist directors of educational programs in setting up core courses. The Subcommittee handbook would be used as a major part of this service.

In pursuing its goals, the Subcommittee will continue to gain input from four groups: the medical profession, hospitals, educational institutions, and the allied health professions.

3. Subcommittee on Equivalency and Proficiency Examinations

Len Hughes Andrus, M.D., Chairman
Nellie May Bering, MT(ASCP)NM
Laura Anne Biglow, RRA
Wesley J. Dulker
Colin R. Macpherson, M.D.
William R. Bishop, Ph.D.

The long range goal of the Subcommittee is to provide guidance in the development of and guidelines for the use of equivalency and proficiency examinations. Toward this end, the Subcommittee is compiling a current report on national activities involving equivalency and proficiency testing; and planning a workshop on major issues concerning this subject to aid those who might be in need of help in constructing proficiency examinations. It was decided at the meeting on October 12, 1972 that an Ad Hoc Committee of the Subcommittee will be appointed, consisting of representatives from the Subcommittee, federal government, health professions organizations, and other groups directly related to the scope of equivalency examinations. This Ad Hoc Committee would plan the workshop (tentatively scheduled for early 1973) to be funded from sources outside of the AMA.

4. Subcommittee on Fees for Accreditation Services

J. Warren Perry, Ph.D., Chairman
Richard A. Ament, M.D.
Warren G. Ball, D.D.S.
David V. Becker, M.D.
Nellie May Bering, MT(ASCP)NM
Laura Anne Biglow, RRA
Betty J. Byers, MT(ASCP)NM
Robert L. Coyle, RT(ARRT)
Frederic Helmholz, Jr., M.D.
William F. Hutson, M.D.
Louise M. Julius, ARIT
L. Don Lehmkuhl, Ph.D.
Edwin Levine, M.D.
Rosser L. Mainwaring, M.D.
Colin R. Macpherson, M.D.
Carol Nathan, OTR
Martha L. Phillips
James P. Steele, M.D.

The Council on Medical Education approves charging limited fees to institutions sponsoring accredited allied health educational programs to pay the actual costs of accreditation work done by the collaborting organizations, with the stipulation that this be considered an emergency measure pending a thorough study and comprehensive approach to the accreditation process in the allied health fields. The Council directs the Advisory Committee on Education for the Allied Health Professions and Services to review each plan for collection of fees before its implementation. However, the fees being charged are increasing and the "emergency measure" is becoming standard operating procedure. The following principles were approved by the Council on Medical Education:

1. Fees for accreditation are to be considered temporary, interim measures.
2. Fees which have been assessed by the Board of Schools and other review committees from 1969 to 1972 were approved by the Council on Medical Education as an interim measure; and the fees currently authorized are approved for a period of one year, subject to re-evaluation by the Council and its Advisory Committee in September of 1973.
3. Renewal of accreditation be dependent upon conformity with all requirements stipulated in the *Essentials*, and in addition, on payment of current and lapsed accreditation fees.
4. Assessment and application fees for accreditation should be used for the payment of actual cost related to accreditation activities at the discretion of the review committee. No honoraria should be paid.
5. Funds collected by review committees should undergo public audit. Copies of this audit should be shared with the Advisory Committee and Council on Medical Education, and should be made available to the sponsoring organizations of the review committee and other interested parties.
6. All review committees, present and future, should be informed of the AMA Office of the General Counsel's opinion that incorporation is desirable if the review committee is to have permanent staff, if sizable funds will be flowing through its office, and if significant liability exposure is possible.

5. Subcommittee on Institutional Approach to Program Evaluation

Nellie May Bering, MT(ASCP)NM, Chairman
Eleanor C. Lambertsen, RN, ED.D.
Warren G. Ball, D.D.S., Secretary

The Subcommittee was formed in response to growing recognition of the need for development of a multidisciplinary approach to evaluation of educational programs for the allied health professions. At institutions conducting three or more teaching programs within the allied health professions, it is anticipated that concurrent surveys by expanded teams, composed of representatives of each occupational area involved, will be appointed.

This procedure will substantially reduce the frequency of site visits to hospitals, colleges and universities, without decreasing the depth and scope of individual program evaluation. Separate survey reports are to be prepared for the consideration of the appropriate review bodies, with each program to be evaluated on the basis of its own merit.

Among the alternative mechanisms currently under consideration by the Subcommittee are the following:

1. Participation in institutional surveys conducted under the auspices of regional accrediting body. This would involve an expanded survey team including at least one and possibly two representatives of each of the professional program areas subject to evaluation. There would be no additional direct expense to the educational institution, beyond the normal fees of the regional agency. Individual program evaluation reports would be forwarded to the regional accrediting body for inclusion in its institutional survey reports, as well as to each of the appropriate review bodies, for consideration and preparation of recommendations to the AMA. It is understood that institutional accreditation would not be contingent upon individual program approach and that each program would be evaluated on the basis of its own merit. Survey schedules would be largely dependent upon those of the regional agency.

2. Institutional survey of allied health professional programs with regional accrediting agency representation. This alternative involves no attempt to schedule site visit evaluations concurrently with those of the regional association. However, a representative of that organization would be invited to participate actively. Invitations could also be extended to other accrediting agencies within the health professions (i.e., American Dental Association, American Dietetic Association, AOTA, APTA) to schedule simultaneous program evaluations. Evaluation reports would be submitted to both the regional accrediting body and to appropriate review bodies for consideration and, again, individual program approval would not be contingent upon approval of other programs conducted by the educational insitution.

3. Multi-disciplinary of institutions with three or more programs within AMA accreditation purview. This alternative is thought to be appropriate for hospital based programs, as well as those of educational institutions offering a small number of allied health professional programs. It involves only an effort to coordinate the schedules of various review bodies in arrangements for concurrent program evaluation with minimal inter-disciplinary involvement. It is not anticipated that regional accrediting body participation would be indicated.

6. Subcommittee on Instructor Preparation

Harry J. Parker, Ph.D., Chairman
Robert L. Coyle, RT(ARRT)
James E. Watt, LTC, MSC
Grace Neitzer, MT(ASCP)BB
Jerry A. Johnson, ORT, Ed.D
Kenneth G. Skaggs, AAJC
Beulah M. Ashbrook, M.Ed., M.A., Secretary

This Subcommittee is assembling information on instructor preparation, with special attention to the development of faculty for allied health programs. The preparation of teachers is of critical importance for the continued expansion of educational programs for allied medical occupations. Information is being gathered on a wide range of programs to qualify instructors in a variety of settings. A growing number of discrete programs for instructor preparation are of interest to experienced allied health professionals who might like to qualify for academic service on a faculty. The Subcommittee is collecting and organizing information on such programs for use by those who would like to become instructors, as well as by administrators who are developing programs to qualify applicants for faculty positions; information can be provided upon request.

7. Subcommittee on Legislation

J. Warren Perry, Ph.D., Chairman
Urban H. Eversole, M.D.
Marvin K. Margo, M.D.
William M. Samuels, ASAHP
Ralph C. Kuhli, M.P.H., Secretary

The primary function of the Subcommittee is to provide a focus for coordination of interests of the allied health and medical specialty societies, as well as other groups concerned, on allied health legislation. The Subcommittee is, therefore, interested in receiving information from other organizations concerning pending legislative proposals, both federal and state. Information should be directed to Mr. Ralph C. Kuhli, Director, Department of Allied Medical Professions and Services. The Subcommittee functions in close cooperation with both the Committee on Legislation of the AMA Council on Medical Education and the AMA Council on Legislation, through the Department of Legislation. Subcommittee members are asked to review and comment on proposed legislation concerning the allied health professions. Their comments are collated and forwarded to the Department of Legislation. Comments may also be submitted concerning AMA positions on pending legislation. The Subcommittee is also concerned with state level legislation affecting allied health occupations, particularly developing legislation concerning physician's assistant educational program standards and utilization of program graduates. The Subcommittee maintains information on such legislation. Information can be supplied in response to individual requests.

8. Subcommittee on Military Allied Medical Education

Capt. James E. Wilson, MC, USN, Chairman
Col. George R. Anderson, USAF, MC
Richard O. Cannon, M.D.
Edward J. Huycke, M.D., Col., MC, USA
Francis L. Land, M.D.
Brig. Gen. Marshall McCabe, MC, USA
Cmr. C. J. Pearce, MSC, USN
Bernard J. Pisani, M.D.
Col. Clifford R. Pollock, USAF, MC
Col. Dale Snyder, MC, USA
Ralph C. Kuhli, M.P.H., Secretary

More than ten million American receive their medical care from the Army, Navy, and Air Force medical services. Education and training for military allied medical workers demand the same standards as those for the civilian components. The objective of the Department of Defense-AMA Subcommittee on Military Allied Medical Education is to make military and civilian educational programs even more effective. This Subcommitte recommended the following policies which have been adopted by the AMA Council on Medical Education: 1) the Council requests all accreditation review bodies involved in allied health education to initiate accreditation activities through a single designated contact office in each branch of the services. 2) the Council expressed its willingness to accredit an allied health educational program conducted by a military service, rather than at one specific location, and 3) the Council will refer to the appropriate review committees for their consideration that survey teams and review committees give special attention to the fact that the clinical portions of military allied medical educational programs include unusually extensive formally supervised clinical educational experience. Other goals established by the Subcommittee include development of common terminology, correlation of curricula, transfer of credit, interorganization communications, and qualification of military allied medical personnel for registration and certification in the several allied health areas. One of the major concerns is the transition of the military medic into the civilian health team. A compilation of the activities and interests of the Subcommittee and other information useful to former corpsmen, professional counselors, potential employers, and other allied health groups including boards of registry is revised regularly and available upon request. This *Compendium of Military Allied Medical Education* can be obtained by writing the AMA Department of Allied Medical Professions and Services.

9. Subcommittee on Research

Members: appointments pending

Miss Beulah N. Ashbrook, M.A., M.Ed., Secretary

Recently approved by the AMA Council on Medical Education, the Subcommittee on Research is intended to work on the validation of the approval process--providing an empirical data base for evaluative procedures which are found to be sound, and strengthening the approval process through changes. Each step to the process is being studied to assure that the methods used to approve educational programs are, in fact, accomplishing the task they should. Those steps involved are 1) standards for approval, 2) application for approval and program self-study, 3) the on-site visit, and 4) evaluation of the reports. As each of these steps is considered, a report will be made available to interested individuals.

10. Subcommittee on Terminology

Barbara White, Chairman
David Becker, M.D.
Sister Bernice Ebner, ARIT
Edwin Levine, M.D.
Dene R. Murray
Don Lehmkuhl, Ph.D., Secretary

The Subcommittee is interested in the vexing problem of terminology; they are involving appropriate national groups of health educators and clinicians to reach a consensus on meanings of key words used in communication about health careers education. Misunderstanding, confusion and ill-will sometimes develop among students, educators and clinicians in various health-related occupations, as well as among spokesmen for different professional organizations. The source of these undesirable reactions can often be identified as lack of uniformity in terminology applied to the various occupational groups. When a given term has different meanings for different people, communication disintegrates and problems multiply. A partial solution lies in attempting to reach consensus about what particular terms are going to mean. Though some groups have developed definitions and a glossary of terms to suit their own needs, specific terms often have a different connotation when applied to situations in other, but related, fields. Cases in point are the terms "therapist," "technician" and "technologist." All of us realize that terminology is a difficult, complex subject which cannot be resolved by one group; nor can it be resolved at one meeting of representatives from many groups. Therefore, we must progress toward general

acceptance of terminology that can be applied to all health occupations. In this way the needs of society, and the needs of each separate organization can be met with a minimum of unnecessary effort being expended to clarify what is meant, and to undo the damage caused by using terms which may induce emotional reactions in another member of the "health team." Continued efforts will be made to resolve problems related to standardization of terminology by the Council on Medical Education's Advisory Committee on Education for the Allied Health Professions and Services, their Panel of Consultants, and the Council on Health Manpower, as well as other appropriate groups involved in this task. Information on the subject of terminology is available from Dr. Lehmkuhl.

ADDITIONAL SERVICES AVAILABLE

A. ALLIED MEDICAL EDUCATION NEWSLETTER • *Mr. Stanley Grubman, B.A.* Information on allied medical education is summarized in brief items which include the addresses of the sources. In the middle of the month these items are edited into a report mailed to arrive on the readers' desks around the first of the month. Distribution is limited to individuals who express their need for the *Newsletter* by writing in to request it. The editorial coordinator provides leads and transmits articles to the editors of AMA journals, magazines, newspapers, and to the editors of periodicals published by other organizations, especially those collaborating with the AMA Council on Medical Education.

B. ALLIED MEDICAL EDUCATION DIRECTORY • *Miss Janice A. Savickas, B.A., and Mr. Stanley Grubman, B.A.* An annual book consisting of tabulations from questionnaires received from administrators of the educational programs approved by the AMA Council on Medical Education, progress reports on major projects of concern to educators, lists of educational programs approved by the Council on Medical Education and collaborating organizations, and an outline (including basic *Essentials*) fro educators considering the development of allied medical educational programs. Work on the *Directory* begins in early Spring with a questionnaire. The answers provide information for an annual report, as well as useful data for collaborating organizations, During the summer the data are programmed into a computer for systematic storage and retrieval -- for future use by the collaborating organizations as well as the AMA. During the fall, the book is edited and printed; publication date is early Spring. The cost is 2.25 per copy.

C. NATIONAL INFORMATION CENTER ON ALLIED MEDICAL EDUCATION • The Center includes the following information: 1. *AMA-Approved Educational Programs,* by state and by city (much is microfilmed; some data is confidential; however, other useful information is readily available on these educational programs, on the schools of allied health, and on the universities and hospitals sponsoring allied medical educational programs); 2. *National Organizations* specifically concerned with allied medical education, with special reference to the associations collaborating with the AMA Council on Medical Education (current addresses and officers, committees concerned with education, and pertinent publications); 3. *Allied Health Occupations* and the educational programs needed to prepare students for these occupations; and 4. *Periodicals* concerned with allied medical education, especially those of the organizations collaborating with the AMA Council on Medical Education. Of course the best way to obtain some of these facts is to visit the National Information Center on Allied Medical Education in the Division of Medical Education on the sixth floor of the AMA headquarters building at 535 North Dearborn Street in Chicago. Also the Center provides answers to specific inquiries by mail or by telephone at (312) 527-1500, extension 739. Requests must be specific, because it is not practical to copy a whole file or shelf of reference material. Educational institutions, national organizations, and editors are encouraged to send copies of new publications for reference in the Center.

E. OCCUPATIONAL LISTS OF APPROVED PROGRAMS (see also *Allied Medical Education Directory*)

Approved Educational Programs for the Assistant to the Primary Care Physician
Approved Educational Programs for the Certified Laboratory Assistant
Approved Educational Programs for the Cytotechnologist
Approved Educational Programs for the Histologic Technician
Approved Educational Programs for the Respiratory Therapist
Approved Educational Programs for the Medical Assistant
Approved Educational Programs for the Medical Laboratory Technician
Approved Educational Programs for the Medical Record Administrator
Approved Educational Programs for the Medical Record Technician
Approved Educational Programs for the Medical Technologist
Approved Educational Programs for the Nuclear Medicine Technician
Approved Educational Programs for the Nuclear Medicine Technologist
Approved Educational Programs for the Occupational Therapist
Approved Educational Programs for the Orthopaedic Physician's Assistant
Approved Educational Programs for the Physical Therapist
Approved Educational Programs for the Radiation Therapy Technologist
Approved Educational Programs for the Radiologic Technologist
Approved Educational Programs for the Specialist in Blood Bank Technology

F. SELF-EVALUATION · Checklists are provided for systematic review of educational programs to assure that they do, in fact, meet (or exceed) the minimal requirements essential for AMA approval. Booklets of these completed forms are provided to members of survey teams as basic information for study before and during site visits. The following sets of forms are available, but distribution is limited to educators requesting accreditation:

Application for Approval of an Educational Program for the Asst. to the Primary Care Physician
Application for Approval of a Program for Certified Laboratory Assistants
Application for Approval of a Program for Cytotechnology
Application for Approval of a Program for Histologic Technician
Application for Approval of an Educational Program for Medical Assistants
Application for Approval of Education Program for the Medical Assistant in Pediatrics
Application for Approval of a Program for Medical Laboratory Technician
Application for Approval for an Educational Program for Medical Record Administrators
Application for Approval for an Educational Program for Medical Record Technicians
Application for an Approved Program of Medical Technology
Application for Approval of an Educational Program in Nuclear Medicine Technology
Application for Accreditation of an Educational Program in Occupational Therapy
Application for Approval of an Educational Program for Orthopaedic Physician's Assistant
Pre-Survey forms--Curriculum in Physical Therapy
Declaration on Intent to Apply for Accreditation--Developing Program in Physical Therapy Education
Pre-Survey forms--School of Radiation Therapy Technology
Pre-Survey forms--School of Radiologic Technology
Application for Accreditation of an Educational Program for the Respiratory Therapist and Respiratory Therapy Technician
Application for Approval of Program for Specialist in Blood Bank Technology
Application for Approval of Educational Program for Urologic Physician's Assistant

G. STANDARDS · The minimal requirements for AMA approval, developed by the twenty-four national professional organizations collaborating with the AMA Council on Medical Education, are referred to as the *Essentials*. Additional suggestions are published in *Guide Books*.

Essentials of an Approved Educational Program for Assistant to the Primary Care Physician (1971)
Essentials of an Acceptable School for Certified Laboratory Assistants (1967)
Essentials of an Acceptable School of Cytotechnology (1967)
Essentials of an Accredited School for Histologic Technicians (1970)
Essentials of an Approved Educational Program for Medical Assistants (1971)
Essentials of an Approved Educational Program for Medical Assistants in Pediatrics (1972)
Essentials of an Accredited Education Program for Medical Laboratory Technicians (1971)
Essentials of an Acceptable School for Medical Record Administrators (1967)
Essentials of an Acceptable School for Medical Record Technicians (1965)
Essentials of an Acceptable School of Medical Technology (1968)
Essentials of an Accredited Educational Program in Nuclear Medicine Technology (1969)
Essentials of an Accredited Curriculum for Occupational Therapists (1965)
Essentials of an Approved Educational Program for the Operating Room Technician (1972)
Essentials of an Accredited Education Program for Orthopaedic Physician's Assistants (1969)
Essentials of an Acceptable School of Physical Therapy (1955)
Essentials of an Accredited School of Radiation Therapy Technology (1968)
Essentials of an Approved Educational Program for the Respiratory Therapy Technician and the Respiratory Therapist (1972)
Essentials of an Accredited Educational Program for Radiologic Technologists (1969)
Essentials of an Approved Educational Program for Specialist in Blood Bank Technology (1971)
Essentials of an Approved Educational Program for Urologic Physician's Assistants (1972)

DEPARTMENT OF ALLIED MEDICAL PROFESSIONS & SERVICES

(Please write directly to the responsible person)

Mr. Ralph C. Kuhli, M.P.H., Director (Surgeon's Assistant)
Miss Martha Hunt, B.S., Administrative Assistant, *(AMA Policy Actions)*
Miss Melanie Rehn, Secretary
ADVISORY COMMITTEE
SUBCOMMITTEE ON LEGISLATION
SUBCOMMITTEE ON MILITARY ALLIED MEDICAL EDUCATION
Operating Room Technician

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(Vacancy) Reference Assistant *(National Information Center)*
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Mrs. Lorraine Arowora, Clerk-Typist

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Mrs. Pauline M. Hinman, B.S., Program Assistant
SUBCOMMITTEE ON CONTINUING EDUCATION
SUBCOMMITTEE ON INSTITUTIONAL APPROACH TO PROGRAM EVALUATION *(Electroencephalographic Technician and Technologist)*
Nuclear Medicine Technician
Nuclear Medicine Technologist
Radiation Therapy Technologist
Radiologic Technologist

(Vacancy) Assistant Director
Mrs. Lois Vlasak, Program Assistant
SUBCOMMITTEE ON EQUIVALENCY AND PROFICIENCY EXAMINATIONS
SUBCOMMITTEE ON FEES FOR ACCREDITATION SERVICES
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Cytotechnologist
Histologic Technician
Medical Laboratory Technician (A.D. Programs)
Medical Technologist
Specialist in Blood Bank Technology

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Miss Sharon Webb, Program Assistant
SUBCOMMITTEE ON COMMON COURSES AND CAREER MOBILITY
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Medical Assistant in Pediatrics
Medical Record Administrator
Medical Record Technician
Urologic Physician's Assistant

Don Lehmkuhl, Ph.D., Assistant Director
Mrs. Sylvia Manning, Program Assistant
SUBCOMMITTEE ON TERMINOLOGY
Occupational Therapist
Orthopaedic Physician's Assistant *(Athletic Trainer)*
Physical Therapist *(Emergency Medical Technician)*
Respiratory Therapist
Respiratory Therapy Technician

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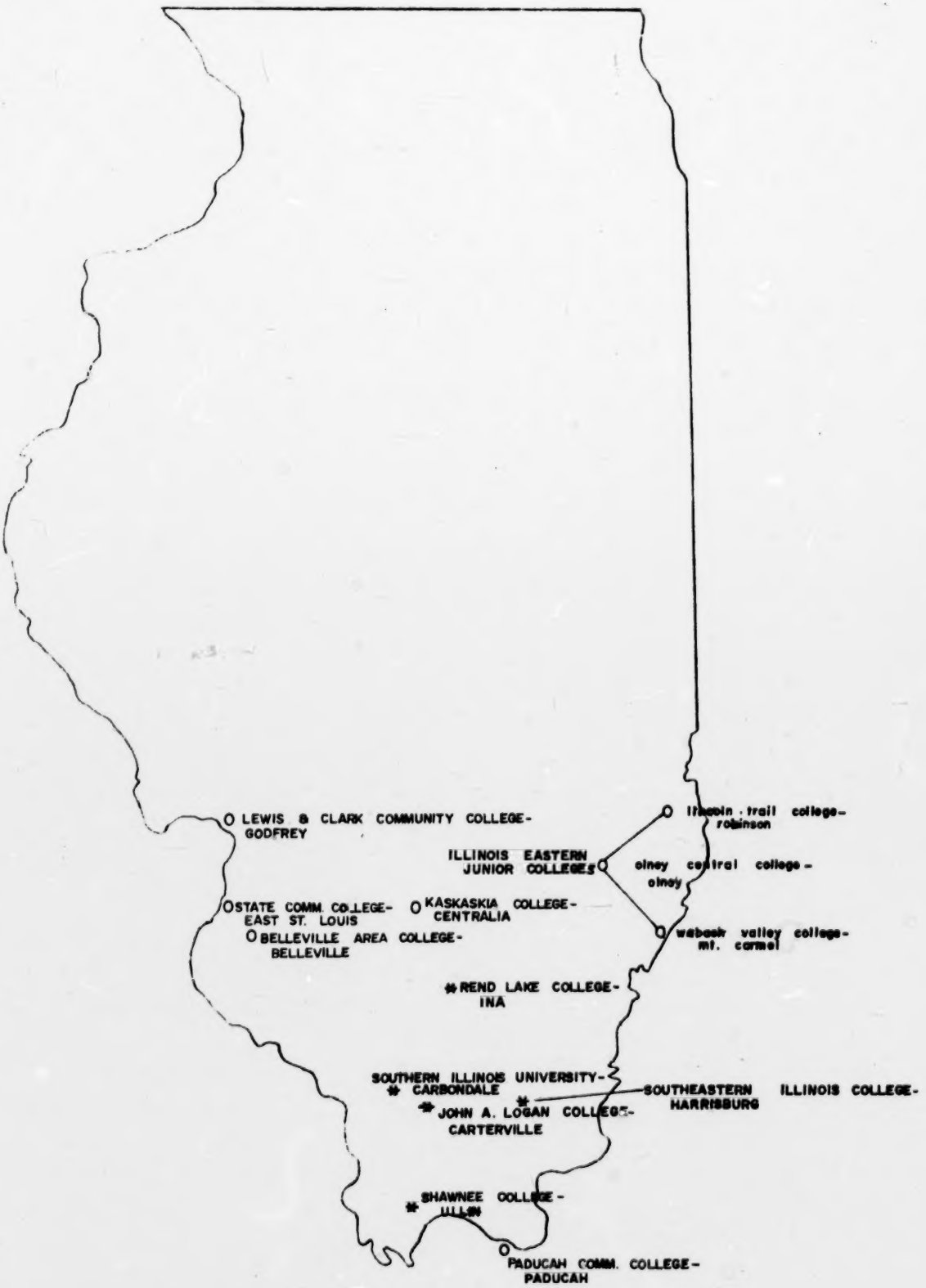
Association for Academic Health Centers



LEGEND

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